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DOCUMENT-IDENTIFIER: US 5845254 A
TITLE: Method and apparatus for objectively monitoring and assessing the performance of health-care providers based on the severity of sickness episodes treated by the providers

Abstract Text (1):
A method and apparatus for objectively monitoring the performance of a group of health-care providers. In-patient payment claim records representative of in-patient health-care services performed for patients by health-care providers within the group of health-care providers and out-patient payment claim records representative of out-patient health-care services performed for patients by health-care providers within group of health-care providers are stored in databases. A plurality of sickness episode data records are built from the in-patient payment claim records and the out-patient payment claim records, and an objective severity adjustment analysis is performed on the sickness episode data records to form a plurality of severity-adjusted sickness episode data records. A cost-efficiency performance level is determined for each individual health-care provider within the group of health-care providers from the plurality of severity-adjusted sickness episode data records, and a qualitative performance level is determined for the group of health-care providers as a whole.

Brief Summary Text (4):
As the cost of health-care continues to rise, increasing numbers of individuals are relying on health-care networks for delivery of health-care services. Typically, a health-care network is made up of a group of health-care providers who contract with a health-care insurer to deliver health-care services to individuals covered by the network. The health-care providers in the network typically include primary-care physicians, specialists, ancillary service providers and hospitals. The covered individuals often subscribe to the network through employers who contract directly the health-care insurer.

Brief Summary Text (5):
In order to efficiently oversee the operation of a health-care network, it is desirable for a health-care administrator to be able to monitor not only the cost of health-care services delivered by each health-care provider in the network, but also the complexity and quality of care delivered and the quality of the results achieved by each health-care provider in the network. For example, a health-care administrator overseeing a network might monitor this type of performance information in order to identify health-care providers in the network that are either overcharging for health-care services, or who may be providing sub-standard care to individuals covered by the network.

Brief Summary Text (6):
At present, the data provided to health-care network administrators from health-care providers in networks relates almost exclusively to the payment of claims. Thus, for example, when a primary care physician has an office visit with an individual covered by the network, the primary care physician will submit a claim record to the network administrator requesting payment for the office visit. The primary goal of the information contained in the claim record is to verify that the event for which payment is sought, e.g., an office visit, is covered by the network health plan. Thus, claim records submitted by individual health-care providers in the network often will not contain a complete picture of a patient's symptoms, all diagnosis that may have been made, all treatments that may have been given and/or the results of all such treatments.

Brief Summary Text (7):
Moreover, it is not uncommon for multiple claim records to be submitted by multiple

health-care providers in the network for a single patient sickness event. For example, a patient having an ulcer might first be seen by a primary-care physician, then by a specialist, and ultimately be admitted to a hospital for in-patient treatment. In this situation, separate payment claim records would typically be submitted by the primary-care physician, the specialist and the hospital. Each of these claim records will typically relate only to work performed by the health-care provider submitting the claim, and will contain data limited to that which is necessary for payment of the claim.

Brief Summary Text (8):
Two different types of claim records have evolved over time in order to facilitate the payment of claims submitted by health-care providers. In particular, claims submitted by health-care providers in the network are typically categorized as either in-patient claims, or out-patient claims. In-patient claims relate to health-care services that have been delivered to an individual who has stayed overnight in the hospital, while out-patient claims relate to health-care services that have been delivered to an individual who has not required a hospital bed day. Thus, there has historically been a clear line delineating claim records pertaining to health-care services delivered to a patient within the overnight hospital environment, and those delivered to a patient outside this environment. This dividing line between services delivered inside and outside the hospital environment exists despite the fact that a single sickness event such as, for example, the ulcer sickness event described above, may typically call for health-care services to be delivered both inside and outside the hospital.

Brief Summary Text (9):
As a result of the historic differentiation between in-patient and out-patient claims, certain standard benchmarks have evolved for evaluating and monitoring the costs of particular claims. These standard benchmarks pertain almost exclusively to in-patient claims, and typically set forth a reasonable cost range that is acceptable for a given in-patient procedure or service. In the past, when a health-care provider in a network submitted a claim for doing a procedure such as, for example, an open-heart surgery, the charge submitted by the provider was compared against the standard benchmark and, if the submitted charge was within the benchmark range, it was paid by the network. In cases where the charges submitted by a health-care provider exceeded the benchmark range, only the portion of the charges within the benchmark range would be paid by the network and the remainder of the claim would be rejected for payment.

Brief Summary Text (10):
The standard benchmarks used in the past typically assumed a median complexity level for each in-patient procedure or service performed by a health-care provider. Thus, there may be a standard benchmark for evaluating the cost of an open-heart surgery procedure regardless of whether a patient has numerous complications (e.g., diabetic, asthmatic, etc.), is mildly complicated, or is otherwise healthy. Use of a standard benchmark for evaluating the costs of all open-heart surgery procedures performed by hospitals within the network may therefore inaccurately portray the cost-efficiency of various hospitals in the network. For example, it may be that certain hospitals in the network routinely handle more complicated open-heart procedures and, even though the costs of these procedures exceed the standard benchmark, the costs are justified in view of the complicated nature of the procedures. Conversely, it may be that certain hospitals in the network routinely handle the least complicated open-heart procedures and, even though the costs of these procedures normally falls below the standard benchmark, the costs are still excessive in view of their uncomplicated nature.

Brief Summary Text (11):
In many health-care networks, certain hospitals have reputations for greater expertise in particular medical areas than other hospitals in the network. For example, it may be that a given health-care network includes a university teaching hospital that is known for its cardiac care capabilities, and a suburban hospital that is known for burn treatment. Although the suburban hospital has a cardiac care department, individuals having more serious and complicated cardiac ailments tend to be treated at the university hospital. Similarly, although the university hospital has a burn treatment department, the more complicated burn cases tend to receive their care at the suburban hospital. In this situation, it would be inappropriate to apply the same standard payment benchmarks for cardiac care and burn treatment to both the university hospital and the suburban hospital. In fact, if the same standard payment benchmarks were applied to both hospitals, it would likely result in the university hospital being routinely under-compensated for its cardiac work and routinely overcompensated for its burn treatment work. Similarly, application of the same standard benchmarks at both hospitals would likely result in the suburban hospital being routinely

under-compensated for its burn treatment work and routinely overcompensated for its cardiac work.

Brief Summary Text (12):
One reason that individuals choose to subscribe to a particular health-care network is the superior reputations for quality and expertise that certain hospitals in the network may have in different areas of medicine. In order to maintain the quality of services and expertise at these hospitals, it is important that each hospital be fully and appropriately compensated for all health-care services that are delivered. Otherwise, if the university hospital was routinely under-compensated for its cardiac work and the suburban hospital was routinely under-compensated for its burn work, these hospitals might lose the financial ability to continue delivering superior health-care services in their respective areas of expertise. If this were to occur, it would be undesirable both for the individuals covered by the network who may no longer have access to superior cardiac and burn care, but also for the entity running the network which may lose the ability to attract new subscribers or retain old subscribers within the network.

Brief Summary Text (13):
In order to fully and appropriately compensate each health-care provider in the network for its services, it is therefore crucial to have a mechanism for objectively measuring the complexity of the cases handled by each provider in the network. Without such information, an administrator overseeing a network has no way of differentiating between the university and suburban hospitals described in the example above. More particularly, the network administrator has no way of identifying that the university hospital is in fact handling the more complicated cardiac cases and that the suburban hospital is handling the more complicated burn cases. Although in the past network administrators may have believed that certain hospitals in the network were handling more complex cases in certain areas, the network administrators have lacked a satisfactory mechanism for objectively quantifying the relative complexity levels of matters handled by different health-care providers in the network. As a result, network administrators have lacked an effective mechanism for adjusting the compensation paid to each health-care provider in the network based on the complexity of the cases handled by each such provider.

Brief Summary Text (15):
In addition to having a system for monitoring and assessing the case load complexity levels handled by each health-care provider in the network, it would be desirable for a health-care administrator overseeing a health-care network to have a comprehensive system for monitoring the performance of all individual health-care providers in the network not only from a cost point of view, but also from a quality of care point of view. Among other things, such a comprehensive system could be used for monitoring on an ongoing basis whether the health-care network as a whole is operating within budgeted limits. In cases where budgetary limits for treating certain conditions have been exceeded, the comprehensive monitoring system could be used to identify which health-care providers (if any) in the network are responsible for the budget overruns.

Brief Summary Text (16):
In addition to these budgetary functions, it would be desirable for the comprehensive monitoring system to have the ability to track the quality of care being delivered by the network as a whole in specific medical areas. For example, it is generally accepted that well-baby visits are beneficial both in maintaining the health of infants and in reducing overall health care costs. Thus, it would be desirable for the comprehensive monitoring system to be able to identify the percentage of infants in the network that are receiving well-baby care, so as to provide an objective measurement of the quality of health-care being delivered to infants in the network. Other objective measurements that would be useful for monitoring the quality of health-care delivered to patients by the network as a whole might include, for example, the percentage of diabetic patients in the health-care network receiving annual eye examinations and the percentage of female patients in the network receiving annual mammograms. It would be useful if such a system for objectively monitoring the quality of care being delivered by the network was coupled to the budget monitoring system described above, so that a network administrator could quickly and easily assess whether budgetary overruns are due to failures by the network's providers to provide the requisite quality of care level to patients in the network.

Brief Summary Text (17):
It is therefore an object of the present invention to provide a health-care monitoring system that can assess the severity of each individual sickness event experienced by

individuals covered by the health-care network.

Brief Summary Text (18):
It is a further object of the present invention to provide a health-care monitoring system that can determine multiple benchmarks for evaluating the cost-effectiveness of a given procedure delivered by health-care providers within the health-care network, the multiple benchmarks corresponding to cases having different severity and complication levels.

Brief Summary Text (21):
It is yet a further object of the present invention to provide a system for objectively assessing the cost-efficiency of each health-care provider within a network on an illness-by-illness basis, wherein the cost-efficiency assessment for each health-care provider is based not only on the cost of the health-care services delivered by the provider, but also on the complexity and severity of the cases treated by the provider.

Brief Summary Text (22):
It is yet a further object of the present invention to provide a comprehensive health-care monitoring system that may be used by an administrator overseeing a health-care network to monitor on an ongoing basis whether the health-care network is operating within budgetary limits, and for objectively assessing the complexity levels of case loads handled by individual health-care providers and the quality of care delivered by all the health-care providers in the network when budgetary limits have been exceeded.

Brief Summary Text (25):
The present invention is directed to a method and apparatus for objectively monitoring the performance of a group of health-care providers. In-patient payment claim records representative of in-patient health-care services performed for patients by health-care providers within the group of health-care providers and out-patient payment claim records representative of out-patient health-care services performed for patients by health-care providers within group of health-care providers are stored in databases. A plurality of sickness episode data records are built from the in-patient payment claim records and the out-patient payment claim records, and an objective severity adjustment analysis is performed on the sickness episode data records to form a plurality of severity-adjusted sickness episode data records. A cost-efficiency performance level is determined for each individual health-care provider within the group of health-care providers from the plurality of severity-adjusted sickness episode data records, and a qualitative performance level is determined for the group of health-care providers as a whole.

Drawing Description Text (3):
FIG. 2 is a diagram showing the data structure of a claim payment record stored in a primary health-care database in accordance with a preferred embodiment of the present invention.

Drawing Description Text (4):
FIG. 3 is a diagram showing the data structure of a claim record stored in a secondary health-care database in accordance with a preferred embodiment of the present invention.

Drawing Description Text (5):
FIG. 4 is a diagram showing the data structure of a patient referral record stored in a utilization management database in accordance with a preferred embodiment of the present invention.

Drawing Description Text (6):
FIG. 5 is a flow diagram showing the operation of a database pre-processing system in accordance with a preferred embodiment of the present invention.

Detailed Description Text (2):
Referring now to FIG. 1, there is shown a block diagram illustrating the operation of a system 100 for objectively monitoring and assessing a group of health-care providers in accordance with a preferred embodiment of the present invention. System 100 is formed of primary health-care information database 10, secondary health-care information database 20, and a utilization management database 30. Records stored in databases 10, 20 and 30 are transmitted in the form of digital signals to database pre-processing system 40, where the records are linked and matched together. The linked and matched

records are then transmitted in the form of digital signals to medical services database 50 for storage. Records stored in medical services database 50 are next transmitted in the form of digital signals to a data processing system 80, which builds a plurality of sickness episode data records by combining information from records stored in database 50. Each sickness episode data record corresponds to an individual sickness episode for which health-care services were performed for a patient by one or more health-care providers. Data processing system 80 also performs an objective severity assessment for each sickness episode data record. In response to each objective severity assessment, data processing system 80 assigns an episode severity score to each of the sickness episode data records. The episode severity scores, together with other information stored in the claim records in database 50, are transmitted in the form of digital signals to a workstation 90. In addition to performing other functions, workstation 90 receives these digital signals from database 50, and determines a case load complexity level for each health-care provider within the group of health-care providers from the severity scores. Each case load complexity level determined by workstation 90 is representative of a patient case load serviced by a particular health-care provider within the group of health-care providers.

Detailed Description Text (3):
Referring now to FIG. 2, there is shown a diagram illustrating the data structure format of an exemplary claim payment record stored in primary health-care database 10 in accordance with a preferred embodiment of the present invention. Each claim record stored in primary health-care database 10 represents a request for payment by a health-care provider for an individual service or procedure performed by the health-care provider for one of the patients in the network. The primary purpose of the information contained in the claim records stored in database 10 is to verify that the service or procedure for which payment is sought, e.g., an office visit, is covered by the network health plan. Since the claim records stored in database 10 relate primarily to claim payment, these claim records will not typically contain a complete picture of a patient's symptoms, all diagnoses that may have been made by the health-care provider submitting the claim record, all treatments that may have been given by the provider submitting the claim record and/or the results of all such treatments.

Detailed Description Text (4):
The claim records stored in primary health-care information database 10 fall into the two claim record categories that have been used historically by health plan administrators for processing claims for payment. Thus, the claims submitted by health-care providers in the network are typically stored in database 10 as either in-patient claim records or out-patient claim records. Each in-patient claim record relates to an individual health-care service or procedure that was performed for a hospitalized patient covered by the network, while each out-patient claim record relates to an individual health-care service or procedure that was performed for a covered patient outside of a hospital. Since a single sickness event such as, for example, arteriosclerosis, may require multiple health-care services and procedures both inside (e.g., angioplasty, bypass surgery) and outside the hospital (e.g., out-patient office visits to primary care physician and cardiologist) from more than one health care provider, multiple different claim records pertaining to a single sickness event (or episode) will typically be stored simultaneously in database 10.

Detailed Description Text (5):
Referring still to FIG. 2, an exemplary data record stored in primary health-care database 10 includes a claim record type field 11 for identifying the type of claim (i.e., in-patient or out-patient) stored in the data record. A provider identification field 12 contains an alphanumeric code representing the health-care provider in the network submitting the claim for payment. A unique health-care provider identification code is used to represent each health-care provider in the network. Each data record stored in database 10 also includes a date-of-service field 13 representing the date on which the health-care provider submitting the claim performed the procedure or service that is the subject of the request for payment. A primary diagnosis code field 14 in the data record contains a code representing a primary diagnosis of a patient's condition that may have been made by the health-care provider submitting the claim. As explained more fully below, a health-care provider may make multiple diagnoses during treatment of an individual patient. However, since only the primary diagnosis is used in processing a claim for payment, only the primary diagnosis is typically stored as part of a claim record in primary database 10. The data record further includes a service provided code field 15 containing a code representing the service or procedure that the health-care provider performed and for which payment is being requested. Field 15 will contain codes representing such things as routine primary care physician office visits, office visits with specialists, specific surgical procedures, specific

diagnostic procedures, etc. A patient account number field 16 in the data record contains a code representing the covered individual for whom the health-care provider performed the service or procedure identified in field 15. The code in the patient account number field 16 may also contain information representing the entity paying the premium for the covered individual such as, for example, the covered individual's employer. Finally, each data record stored in database 10 will preferably include a remark code field 17 that the network administer may use for storing payment processing information. The remark code field 17 may be used, for example, to store a code indicating that the administrator declined to pay the claim to health-care provider because the individual identified in field 16 had a policy with a deductible amount that had not yet been met.

Detailed Description Text (6):
Although FIG. 2 shows a specific data structure format having specific fields ordered in a particular sequence, it will be understood by those skilled in the art that other data structure formats with different fields ordered in other sequences may be used for storing data records in primary health-care database 10.

Detailed Description Text (7):
Referring now to FIG. 3, there is shown a diagram illustrating the data structure of a claim record stored in secondary health-care database 20 in accordance with a preferred embodiment of the present invention. Although only information necessary for payment of a claim is typically stored in primary database 10, it is common that health-care providers submitting claims for payment will also include supplemental information in their claim submission forms which does not correspond to a data record field stored in primary health-care database 10. In the past, since this supplemental information was not required to process the claim for payment, the supplemental information was typically discarded after the claim record in primary database 10 was in place. In the present invention, such supplemental information is retained in a supplemental data record stored in secondary health-care information database 20.

Detailed Description Text (8):
Referring still to FIG. 3, an exemplary data record stored in secondary health-care database 20 includes a claim record type field 21 for identifying the type of claim associated with the data record; a provider identification field 22 containing an alphanumeric code representing the health-care provider in the network associated with the claim; a date-of-service field 23 representing the date of service associated with the claim; a service provided code field 24 containing a code representing the service or procedure that the health-care provider performed; and a patient account number field 25. Fields 21, 22, 23, 24 and 25 correspond substantially to fields 11, 12, 13, 15 and 16 discussed more fully above. The data records stored in database 20 also include a secondary diagnosis code field 26a, a tertiary diagnosis code field 26b, a fourth diagnosis code field 26c and a fifth diagnosis code field 26d. As mentioned above, although a health-care provider submitting a claim may make multiple diagnoses during treatment of an individual patient, only the primary diagnosis is used for processing the claim for payment. All diagnoses other than the primary diagnosis are saved by the present invention and stored in the form of codes in fields 26a-d. Each data record stored in database 20 also includes a hospital revenue code field 27 which is used to identify an entity within a hospital that performed a service or procedure for which payment is being requested. By way of example, field 27 may be used to indicate whether a patient received care in a regular care room or an intensive care unit.

Detailed Description Text (9):
Although FIG. 3 shows a specific data structure format having specific fields ordered in a particular sequence, it will be understood by those skilled in the art that other data structure formats with different fields ordered in other sequences may be used for storing data records in secondary health-care database 20.

Detailed Description Text (10):
Referring now to FIG. 4, there is shown a diagram illustrating the data structure of a patient referral record stored in utilization management database 30 in accordance with a preferred embodiment of the present invention. The purpose of each referral record stored in database 30 is to maintain an audit trail of referrals initiated by each primary care physician in the network. Each data record stored in database 30 contains a patient account number field 31 containing a code representing the identity of the covered individual that is the subject of the audit trail. A primary care physician code field 32 is provided for storing a code representing the primary care physician who initially referred the patient identified in field 31 to a further health-care

provider. A code corresponding to the identity of the health-care provider that received the initial referral from the primary care physician is stored in field 33. In the event the provider identified in field 33 found it necessary to refer the patient to a further health-care provider or to a hospital, a code representing the provider receiving the further referral would be stored in fields 34 or 35, respectively. Although FIG. 4 shows a specific data structure format having specific fields ordered in a particular sequence, it will be understood by those skilled in the art that other data structure formats with different fields ordered in other sequences may be used for storing data records in utilization management database 40.

Detailed Description Text (11):
Referring now to FIG. 5, there is shown a flow diagram illustrating the operation of a database pre-processing system 40 in accordance with a preferred embodiment of the present invention. Database pre-processing system 40 preferably receives digital signals from databases 10, 20 and 30 representative of the records stored in these databases, processes these signals, and then transmits digital signals representative of records that have been linked and matched in accordance with the process of FIG. 5 to medical services database 50. The purpose of data pre-processing system 40 is to link together related records stored in databases 10, 20 and 30 prior to the storage of such records in medical services database 50. For purposes of database pre-processing system 40, two or more data records are considered related if they pertain to the same sickness event experienced by an individual covered by the network. Thus, for example, if an individual covered by the network had a sickness event such as an ulcer, and the covered individual saw a primary care physician, then a specialist, and was ultimately admitted to a hospital for treatment, the following related data records would likely exist for this sickness event in databases 10, 20 and 30: (1) three primary claim records (one for the primary care physician, one for the specialist, and one for the hospital) would be stored in primary health-care database 10, (2) three corresponding supplemental claim records would be stored in secondary health-care database 20, and (3) a data record would be stored in utilization management database 30 showing the referral path of the patient from the primary care physician, to the specialist, and ultimately to the hospital. As explained more fully below, database pre-processing system 40 scans all the records in databases 10, 20 and 30 and, based on the information contained in those records, links together each group of records that are related to the same sickness event. Database pre-processing system 40 is preferably implemented in software on a microprocessor or a general purpose digital mainframe computer.

Detailed Description Text (12):
Referring still to the flow diagram of FIG. 5, in step 42, data pre-processing system 40 matches together related data records from databases 10, 20 and 30. In step 42, data records from databases 10 and 20 are initially linked together into sub-groups of data records sharing the same patient identification code, health-care provider code, and date-of-service code. Thereafter, the records from database 30 are scanned to determine if there is a referral record in database 30 associated with any of the sub-groups of records initially linked together from databases 10 and 20. Each sub-group of data records associated with the same referral record is then linked together into a group of data records. A directory containing the addresses of the data records in each record group and sub-group is formed in step 42 and stored in medical services database 50.

Detailed Description Text (15):
Referring now to FIG. 6, there is shown a flow diagram showing the operation of an episode builder and severity adjustment analysis system 80 in accordance with a preferred embodiment of the present invention. Episode builder 80 preferably receives digital signals from database 50 representative of records stored in the database, processes these signals, and then transmits digital signals representative of episodes built and episode severity scores determined in accordance with the process of FIG. 6 to medical services database 50.

Detailed Description Text (16):
In step 82, system 80 uses the data record groups and sub-groups formed by system 40 to build a plurality of sickness episode data records. Each sickness episode data record built by system 80 corresponds to an individual "sickness episode" during which health-care services were performed for a patient by at least one health-care provider from the health-care network. In the preferred embodiment, the term "sickness episode" corresponds to a time period that begins when a patient is injured or begins to feel sick and ends when the patient is no longer sick or injured. Since a patient may begin to feel sick prior to seeing a health-care provider from the network, a sickness

episode may begin before any health-care services are provided for the patient by any health-care provider in the network. In addition, since a patient may see several health-care providers in the network during a single sickness episode, a typical sickness episode data record may include information about both in-patient and out-patient services that were provided to the patient during the episode.

Detailed Description Text (17):
Among other things, each sickness episode data record built by system 80 will contain data representative of all diagnoses pertaining to the sickness episode, and all procedures and services performed by each health-care provider in the network in connection with the sickness episode. The diagnoses included in each sickness episode data record will include all diagnoses rendered by the health-care providers that were involved in the sickness episode, regardless of whether such diagnoses were rendered in connection with in-patient or out-patient services. Similarly, since a typical sickness episode may call for both in-patient and out-patient services, a sickness episode data record may contain data representing both in-patient and out-patient services and procedures that were performed for a patient during the episode.

Detailed Description Text (19):
In step 86, each sickness episode data record that was classified as complicated is subjected to a severity adjustment analysis. The purpose of the severity adjustment analysis is to objectively rank (or score) the complexity of the sickness episode embodied in the data record. In the preferred embodiment, the severity adjustment analysis uses information from the diagnoses and procedures stored in the sickness episode data record to assign a numerical severity score ranging from 1 (least severe) to 16 (most severe) to the sickness episode data record. After each sickness episode data record that was classified as complicated has been subjected to a severity adjustment analysis in step 86, the sickness episode data records together with their assigned severity scores are stored in medical services database 50. Episode builder and severity adjustment system 80 is preferably implemented in software on a microprocessor or a general purpose digital mainframe computer.

Detailed Description Text (20):
Referring now to FIG. 7, there is shown a flow diagram illustrating the operation of a system 200 for objectively monitoring and assessing the performance of a group of health-care providers in accordance with a preferred embodiment of the present invention. System 200 is preferably implemented in software on a workstation 90. By way of an overview, system 200 includes three sub-systems. The first sub-system includes steps 210-240 and is used for monitoring on an ongoing basis and at regular intervals whether the costs being expended by the network as a whole for treating various conditions are within predetermined budgetary levels, or alternatively, whether the network as a whole is having budget overruns in connection with its treatment of such conditions. The second sub-system includes provider profiler system 300 and is explained more fully in conjunction with FIGS. 8, 9, 10, 11 and 11A. The third sub-system includes qualitative performance summary system 400, which is used for objectively determining and assessing the qualitative performance level of the network as a whole in treating various conditions. In the preferred embodiment shown in FIG. 7, sub-systems 300 and 400 are used in conjunction with the budget monitoring sub-system (steps 210-240) in order to attempt to identify potential causes or reasons for budgetary overruns identified by the budget monitoring sub-system. It will be understood by those skilled in the art that sub-systems 300 and 400 may be used in a stand-alone mode, separate and apart from the budget monitoring system of steps 210-240, for performing provider profiling and determining qualitative performance levels associated with conditions and procedures other than those identified by the budget monitoring system.

Detailed Description Text (21):
Referring still to FIG. 7, in step 210 the budget monitoring sub-system selects a medical condition for cost assessment. The selected condition will correspond, for example, to a specific medical condition typically treated by health-care providers in the health-care network. In step 220, the budget monitoring sub-system determines the actual costs expended by all providers in the network in treating the selected condition. Thus, for example, if the condition selected in step 210 corresponded to severe coronary artery blockage, the actual cost figure determined in step 220 may include all costs spent by the network as a whole in performing coronary bypass surgery. In steps 230 and 240, the actual cost figure expended on the selected condition is compared against a predetermined budgeted cost amount for treating the selected condition. In one embodiment, this predetermined budget cost amount is determined by looking at amounts previously expended by the network on treating the

selected condition, and then using these previous expenditure amounts as a basis for projecting what amounts should be budgeted presently for treating the selected condition. If in step 240 the budget monitoring sub-system determines that the actual cost for treating the selected condition exceeds the budgeted amount for treating the condition, then systems 300 and 400 are employed to attempt to identify the cause of the overrun. Alternatively, if no budgetary overrun is identified in step 240, then the process is repeated from step 210 for a further selected condition. In the preferred embodiment, the budget monitoring sub-system of steps 210-240 is used on a regular basis (e.g., weekly, monthly or quarterly) to evaluate each condition typically treated by providers in the network and determine whether the costs expended in treating each such conditions are within budgeted amounts.

Detailed Description Text (22):
Referring still to FIG. 7, in the event that the budget monitoring sub-system determines that there has been a budgetary overrun in connection with the selected condition, provider profiler system 300 (shown and described in connection with FIGS. 8, 9, 10, 11 and 11A) is used to identify those health-care providers in the network that have performed inefficiently from a cost standpoint in treating the selected condition. In addition, in instances where budgetary overruns are present, system 400 may be used to determine whether the quality of care being delivered in treating the selected condition is up to a predetermined standard. It is important to assess the quality of care for those conditions that involve budgetary overruns, because a sub-standard quality of care level can often result in the expenditure of excess amounts for medical costs.

Detailed Description Text (23):
Referring still to FIG. 7, qualitative performance summary system 400 is provided for objectively measuring the qualitative performance of the network as a whole in treating a selected condition. Examples of objective qualitative performance levels determined by system 400 might include the percentage of young children covered by the network that have received "well-baby" care, the percentage of diabetic patients in the network that have received annual eye exams, and the percentage of female patients in the network receiving annual mammograms. System 400 preferably determines each of these percentages by evaluating the claim records stored in databases 10, 20, 30 and 50, and then compares each such percentage to an industry standard to determine whether the quality of care being delivered by the network as a whole is up to industry standards. In instances where there has been a budgetary overrun and the quality performance percentage associated with treating the selected condition (from step 210) is below the industry standard, this fact is signalled to the network administrator through workstation 90. The administrator may then take corrective action by, for example instructing the providers in the network to schedule and perform further procedures so as to improve the quality performance percentage of the network as a whole for the selected condition.

Detailed Description Text (24):
In the preferred embodiment of the present invention, workstation 90 is also coupled through database 50 to an automatic auditing system 60 for auditing individual in-patient and out-patient claim records stored in database 50. Auditing system 60 can be accessed on workstation 90 through interface software resident on the workstation. The purpose of the automatic auditing system is to review each claim record submitted for payment by a health-care provider, and identify certain sentinel events that are evidenced by the claim records. Such sentinel events may include, for example, experimental or unwarranted medical procedures that are not approved for coverage by the network.

Detailed Description Text (25):
Referring now to FIG. 8, there is shown a flow diagram showing the operation of a provider profiler system 300 for assessing the performance of individual health-care providers within a network of health-care providers in accordance with a preferred embodiment of the present invention. System 300 is preferably implemented in software on workstation 90. As discussed more fully below, the operation of system 300 may be broken down into three main steps, each of which is comprised of several sub-steps. In main step 320, one or more severity comparison benchmarks are determined for each common procedure that was performed by the health-care providers in the network. Next, in main step 340, case load complexity levels representing the overall severity of cases handled by a health-care provider are determined for each health-care provider in the network. Finally, in main step 360, a cost-efficiency assessment is performed on each health-care provider in the network based on the benchmarks from step 340. As explained more fully below, the purpose of using the severity comparison benchmarks in

assessing the cost-efficiency of the health-care providers is to insure that health-care providers that routinely handle more complicated cases are compared from a cost standpoint against like health-care providers that also routinely handle more complicated cases, and that health-care providers that routinely handle less complicated cases are compared from a cost standpoint against like health-care providers that also routinely handle less complicated cases. Thus, the use of the severity comparison benchmarks in the present invention insures that the exemplary university and suburban hospitals discussed in the background of this specification would never be compared against each other from a cost standpoint in assessing the cost-efficiencies of their respective cardiac and burn treatment units.

Detailed Description Text (26):
Referring now to FIG. 9, there is shown a flow diagram illustrating the operation of main step 320 and showing a system for determining severity comparison benchmarks that are used for assessing the relative performance of individual health-care providers within a group of health-care providers in accordance with a preferred embodiment of the present invention. In step 322, a common procedure or service performed by multiple health-care providers in the network for patients is selected for analysis. When sub-system 300 is used in conjunction with the budget monitoring sub-system (steps 210-240) of system 200, the common procedure or service may correspond, for example, to the procedure typically used for treating the condition selected in step 210. In step 324, each sickness episode data record in database 50 is scanned and each sickness episode data record which includes a procedure code showing that the selected common procedure was performed during the sickness episode by any health-care provider in the network is selected. In step 326, a plurality of complexity ranges are determined for the selected common procedure by analyzing the severity scores associated with the sickness episode data records selected in step 324. In one embodiment, the severity scores associated with the selected sickness episodes are arranged in ascending order and the list is then divided at its midpoint into a first group of less severe severity scores and a second group of more severe severity scores. In step 328, a severity comparison benchmark is determined for each of the complexity ranges determined in step 326. Thus, in the embodiment discussed above, a first severity comparison benchmark is determined from the first group of less severe severity scores and a second severity comparison benchmark is determined from the second group of more severe severity scores determined in step 326. The first severity comparison benchmark is preferably determined by either averaging or taking the statistical median of the first group of less severe severity scores, and the second severity comparison benchmark is preferably determined by either averaging or taking the statistical median of the second group of more severe severity scores. It will be understood by those skilled in the art that the severity scores selected in step 324 may divided into more than two complexity ranges, and that statistical techniques other than averaging or median selection may be used to determine severity comparison benchmarks from such complexity ranges. The process of determining severity comparison benchmarks may be repeated (as shown by block 330) on a procedure-by-procedure basis for each procedure or service performed by health-care providers in the network.

Detailed Description Text (27):
Referring now to FIG. 10, there is shown a flow diagram illustrating the operation of main step 340 and showing a system for determining individual case load complexity levels for individual health-care providers within a network of health-care providers in accordance with a preferred embodiment of the present invention. In step 342, a common procedure or service performed by multiple health-care providers in the network for patients is selected for analysis. When sub-system 300 is used in conjunction with the budget monitoring sub-system (steps 210-240) of system 200, the common procedure or service may correspond, for example, to the procedure typically used for treating the condition selected in step 210. In step 344, a health-care provider from the network is selected for evaluation. In step 346, a case load complexity level associated with the selected common procedure is determined for the selected provider. In this step, all sickness episode data records are identified wherein the selected health-care provider performed the common procedure for a patient covered by the network. The severity scores assigned to the identified sickness episode data records are then either averaged or a median of these scores is taken to determine a case load complexity level associated with the selected common procedure for the selected provider. It will be understood by those skilled in the art that statistical techniques other than averaging or median selection may be used to determine a case load complexity level from associated severity scores in step 346. As shown by blocks 348 and 350, the process of determining case load complexity levels is preferably repeated on a provider-by-provider basis for each procedure or service performed by health-care providers in the network.

Detailed Description Text (28):
Referring now to FIGS. 11 and 11A, there is shown a flow diagram illustrating the operation of main step 360 and showing a system for assessing the cost-efficiency of individual health-care providers within a group of health-care providers in accordance with a preferred embodiment of the present invention. In step 362, a common procedure or service performed by multiple health-care providers in the network for patients is selected for analysis. When sub-system 300 is used in conjunction with the budget monitoring sub-system (steps 210-240) of system 200, the common procedure or service may correspond, for example, to the procedure typically used for treating the condition selected in step 210. In step 364, one of the severity comparison benchmarks (from step 328) associated with the selected procedure is selected for analysis. In step 366, all health-care providers in the network with case load complexity levels for the common procedure that are within a predetermined range of the selected benchmark are identified. In step 368, an average cost charged for performing the selected procedure is determined for each health-care provider that was identified in step 366. More particularly, for each health-care provider identified in step 366, the costs charged by the health-care provider for performing the selected procedure are extracted from the claim records stored in database 50 and then averaged. In step 370, an aggregate average cost charged for performing the selected procedure is determined based on each health-care provider that was identified in step 366. More particularly, in step 370, the costs charged for performing the selected procedure by all health-care providers across the network that were identified in step 366 are extracted from the claim records stored in database 50, added together on an aggregate basis, and then averaged. In step 372, a cost-efficiency performance level for each health-care provider that was identified in step 366 is determined by comparing the individual average cost charged by the health-care provider for performing the selected procedure (determined in step 368) with the aggregate average cost charged for performing the selected procedure across the network (determined in step 370). In a preferred embodiment, the selected health-care provider will be classified as having an "efficient" cost-efficiency performance level so long as the provider's individual average cost charged for the selected procedure is within a predetermined percentage of the aggregate average cost charged across the network for the procedure; otherwise, the selected provider will be classified as having an "inefficient" cost-performance level and will be flagged for review by workstation 90. As shown by blocks 376 and 378, the process of assessing the cost-performance levels of the health-care providers in the network may be repeated for each severity comparison benchmark associated with the selected procedure, and then on a procedure-by-procedure basis for each procedure or service performed by health-care providers in the network.

Detailed Description Text (29):
Since severity comparison benchmarks are used in main step 360 in assessing the cost-efficiency performance levels of the individual health-care providers in the network, the present invention insures that health-care providers that routinely handle more complicated cases are compared from a cost standpoint only against like health-care providers that also routinely handle more complicated cases, and that health-care providers that routinely handle less complicated cases are only compared from a cost standpoint against like health-care providers that also routinely handle less complicated cases.

CLAIMS:

1. An apparatus for objectively monitoring the performance of a group of health-care providers, comprising:

(A) a database storage means for storing in-patient payment claim records representative of in-patient health-care services performed for patients by health-care providers within said group of health-care providers and out-patient payment claim records representative of out-patient health-care services performed for said patients by health-care providers within said group of health-care providers;

(B) episode building means, coupled to said database storage means, for building a plurality of sickness episode data records from said in-patient payment claim records and said out-patient payment claim records;

(C) severity adjustment means, coupled to said episode building means, for performing an objective severity adjustment analysis on said plurality of sickness episode data records to form a plurality of severity-adjusted sickness episode data records; and

(D) a computer workstation, coupled to said database storage means, said computer workstation including:

(i) cost-efficiency performance assessment means, responsive to said plurality of severity adjusted sickness episode data records, for objectively determining a cost-efficiency performance level for each individual health-care provider within said group of health-care providers;

(ii) qualitative-performance assessment means, responsive to said in-patient payment claim records and said out-patient payment claim records, for objectively measuring a qualitative performance level of said group of health-care providers as a whole; and

(iii) budget monitoring means for determining a total illness cost value representing costs incurred by said group of health-care providers as a whole for treating a selected condition and comparing said total illness cost value to a predetermined budgeted illness cost value associated with said selected condition.

11. A computer-implemented method for objectively monitoring the performance of a group of health-care providers, comprising the steps of:

(A) storing in a database storage means in-patient payment claim records representative of in-patient health-care services performed for patients by health-care providers within said group of health-care providers and out-patient payment claim records representative of out-patient health-care services performed for said patients by health-care providers within said group of health-care providers;

(B) building a plurality of sickness episode data records from said in-patient payment claim records and said out-patient payment claim records;

(C) performing an objective severity adjustment analysis on said plurality of sickness episode data records to form a plurality of severity-adjusted sickness episode data records;

(D) objectively determining a cost-efficiency performance level for each individual health-care provider within said group of health-care providers from said plurality of severity-adjusted sickness episode data records;

(E) objectively measuring a qualitative performance level of said group of health-care providers as a whole; and

(F) determining a total illness cost value representing costs incurred by said group of health-care providers as a whole for treating a selected condition and comparing said total illness cost value to a predetermined budgeted illness cost value associated with said selected condition.

21. An apparatus for objectively monitoring the performance of a group of health-care providers, comprising:

(A) a database storage means for storing in-patient payment claim records representative of in-patient health-care services performed for patients by health-care providers within said group of health-care providers and out-patient payment claim records representative of out-patient health-care services performed for said patients by health-care providers within said group of health-care providers;

(B) episode building means, coupled to said database storage means, for building a plurality of sickness episode data records from said in-patient payment claim records and said out-patient payment claim records;

(C) severity adjustment means, coupled to said episode building means, for performing an objective severity adjustment analysis on said plurality of sickness episode data records to form a plurality of severity-adjusted sickness episode data records; and

(D) a computer workstation, coupled to said database storage means, said computer workstation including:

(i) cost-efficiency performance assessment means, responsive to said plurality of severity adjusted sickness episode data records, for objectively determining a cost-efficiency performance level for each individual health-care provider within said group of health-care providers;

(ii) qualitative-performance assessment means, responsive to said in-patient payment claim records and said out-patient payment claim records, for objectively measuring a qualitative performance level of said group of health-care providers as a whole based on preventive-care services associated with a selected condition; and

(iii) budget monitoring means for determining a total illness cost value representing costs incurred by said group of health-care providers as a whole for treating a selected condition and comparing said total illness cost value to a predetermined budgeted illness cost value associated with a selected condition.

25. A computer-implemented method for objectively monitoring the performance of a group of health-care providers, comprising the steps of:

(A) storing in a database storage means in-patient payment claim records representative of in-patient health-care services performed for patients by health-care providers within said group of health-care providers and out-patient payment claim records representative of out-patient health-care services performed for said patients by health-care providers within said group of health-care providers;

(B) building a plurality of sickness episode data records from said in-patient payment claim records and said out-patient payment claim records;

(C) performing an objective severity adjustment analysis on said plurality of sickness episode data records to form a plurality of severity-adjusted sickness episode data records;

(D) objectively determining a cost-efficiency performance level for each individual health-care provider within said group of health-care providers from said plurality of severity-adjusted sickness episode data records;

(E) objectively measuring a qualitative performance level of said group of health-care providers as a whole based on preventive-care services associated with a selected condition; and

(F) determining a total illness cost value representing costs incurred by said group of health-care providers as a whole for treating a selected condition and comparing said total illness cost value to a predetermined budgeted illness cost value associated with said selected condition.

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DOCUMENT-IDENTIFIER: US 6012035 A
TITLE: System and method for supporting delivery of health care

Abstract Text (1):
Effectuation of a health care provision agency cooperative function is established through a communication network linking all the various entities of the cooperative. The entities include the third party payor members, the health providing individuals, clinics, or the like, along with secondary providers including pharmacies and laboratories, health care facilities such as hospitals, and the several entities associated with management of the cooperative and appropriate funds transfer functions. A coordinating interface system maintains data storage of the necessary information, and manages the entity intercommunications in accordance with the basic structure of the active and eligible elements of the agency cooperative.

Brief Summary Text (3):
The present invention relates to systems and processes for supporting the delivery of health care to individuals. More particularly, the present invention relates to devices and methods dedicated to effectuating the provision and management of a cooperative health care system in connection with an integrated cooperative group of entities. The present invention is concerned with a new paradigm of systems concerned with, and supported by, communications and computer networks and methods of using the same for providing medically oriented services while coordinating the various functions associated therewith.

Brief Summary Text (5):
Historically, the dispensation of health care has generally occurred in a fragmented manner. Typically, individuals obtain medical services from health care providers; i.e., physicians, pharmacies, hospitals, or the like as needed. Increasingly over the past sixty years, these services have received coverage by some form of third party payor, such as the employer, the government, or an insurance mechanism, with the balance payment remaining the responsibility of the patient. Sometimes the patient pays directly for the services, and sometimes payment is effected by use of credit through a credit card company or the like. At other times, claims are submitted by the patient or by the provider to an insurance company who then pays the provider, patient, or both, as appropriate. There are many inefficiencies and inequalities inherent in this disjointed health care system and procedure.

Brief Summary Text (6):
Some business organizations have sprung up as health maintenance organizations which have prearranged service availability with particular health care providers where access, availability and methodology of treatment modalities are directly related to the structure and the payment mechanism inherent in vertically oriented organizations and related systems. Such arrangements tend to restrict the ability of the patient to select someone better known, or more desirable as a particular health care provider, to handle the particular problem.

Brief Summary Text (7):
Some prior art medical applications have employed computer systems and communications networks for various purposes. For example, U.S. Pat. No. 5,065,315 by Garcia employs a computer-based system for collecting patient data and producing time oriented task lists within a given hospital facility. In U.S. Pat. No. 4,491,725 by Pritchard, medical insurance coverage verification is initiated from a patient identifying card so as to access a central database through a data processing network.

Brief Summary Text (8):
Still other data processing systems have utilized computer programs, computers and data

processing communication networks to interconnect a plurality of care providers, banks and insurance companies through a central computer to allow determinations of coverage and payments for patients, such as in U.S. Pat. No. 4,858,121 by Barber et al, U.S. Pat. No. 4,916,611 by Doyle et al, and U.S. Pat. No. 5,070,452 by Doyle et al. Such prior art arrangements have not provided the systems and methods for effectuating a fully integrated and cooperative system for dispensing and managing health care.

Brief Summary Text (10):
The functions associated with health care provision assistance, in accordance with the present invention, advantageously utilize communicating computer equipment and a multiplicity of interconnected terminals and locations all associated with one or more of the multiple facets of an agency-cooperative health care provision and management system. Health care providers (such as doctors, hospitals, pharmacies and the like), insurance companies (including employer self insurance programs, no fault insurance programs, and government programs) and a financial institution are connected via computer terminal to a central data switch and repository computer which provides the interface between the terminals and records every transaction among the terminals. The data switch and repository is also connected to terminals associated with a coordinated management system. The management system handles the system housekeeping functions of the cooperative by monitoring the databases within the repository to ensure adequate performance by service providers and insurance companies.

Brief Summary Text (11):
A qualified member is issued an electronic card, or the like, by the financial institution, which also provides a credit level to the member. When the member visits a health care provider, the provider sends a diagnostic code to the member's insurance company and requests an authorization code which indicates the eligibility of the member for health care. The financial institution indicates whether the member has credit. After the member has received medical treatment, the provider submits a claim to the insurance company, which adjudicates the claim and notifies the financial institution to pay the claim on behalf of the third party payor and the insured member. The financial institution pays the provider's claim in full, minus a transactional fee used to pay for the bank's services and a reserve account to cover bad debt and charity care. The insurance company, or third party payor, sends an explanation of benefits to the provider, and also to the member showing which portion of the claim was paid by the insurance company and which must be paid by the patient. The bank bills the patient for the patient's share of the provider's bill which the bank has advanced. The patient and insurance company bills include a service charge to pay for the data switch and repository and management services. The bank also sends a detailed financial transaction report to the provider.

Brief Summary Text (12):
All of the transactions among the provider, insurance company, and financial institution are interfaced through the data switch and repository which records each transaction. The data switch and repository could consist of all of the databases located at the various entities. However, for redundancy and backup, in the preferred embodiment, the data switch and repository is a separate database which downloads and records all of the transactions between the entities of the system. Thus, the repository can provide statistical reports to the providers, insurance companies, and management service which are useful in assessing such matters as treatment effectiveness, insurance company performance, profitability, and conformance with cooperative group requirements.

Brief Summary Text (14):
The system and method of this invention is directed to the purpose of effectuating the operation of a cooperative agency organization dedicated to health care provision and management amongst a plurality of groups of entities. These entities include health care providers, health care facilities, a financial institution and third party payor members each of which has one or more health care users as constituents. A data switch and repository interfaces among these entities and the management service and stores records of all transactions between the entities.

Brief Summary Text (15):
A plurality of terminals are assigned to respective entities of the cooperative agency organization, and a data switch and repository interfaces among the entities' terminals for determining that a user is eligible for health care and for authorizing funds transfers correlated to services provided by a cooperative health provider to an authorized user. A particularly attractive device for facilitating determination of eligibility is the contemporary electronic cards each assigned to a respective one of

the members for enabling automatic communication with the information storage. Such a card acts as a national bank credit card for health care for the insured member, as an I.D. card for the insurance company, as an access card to the system, and as a vehicle for health care providers to submit claims and get paid.

Brief Summary Text (17):
The method of this invention likewise effectuates the monitoring and management of a cooperative health care provision system through a management service. As mentioned, these entities typically include health care providers, health care facilities, a financial institution, and third party payors or subscribers who have one or more health care users as members. The method includes the initial and subsequent steps of providing interfacing between the entities, storing records of a transactions between entities, and providing statistical reports based on the transactions.

Brief Summary Text (18):
A request for information from a provider causes a response by determining that the provider is included in the listing of active members. A provider favorably thus determined in accordance with the responding step is allowed to have access to the database for determining that a user is eligible for health care and has credit. Thereafter, funds transfers are authorized in correlation to services provided by a cooperative health provider to an authorized user.

Brief Summary Text (19):
The system administrative time is reducible by the step of enabling the health care providers and health care facilities to cooperatively provide health care service to a user after a favorable determining response has resulted from the original provider inquiry.

Detailed Description Text (2):
FIG. 1 shows the interactions and communication between entities which cooperate as a collaborative health care system according to the present invention. The agency cooperative interface management system 10 is shown at the center of the diagram because management system 10 monitors and manages the system. Other elements of the system include administrative services terminals 35, purchasing members terminals 30, insurance company member terminals 25, secondary provider terminals 20, hospital facility terminals 15, and primary provider terminals. Communications occur between and among the entities' terminals through communications lines 12, 16, 17, 18, 21, 22, 26, 31, 32, 33, 36, and 37.

Detailed Description Text (3):
More particularly, FIG. 1 presents a general block diagram of the system configuration for a typical data processing network to effectuate the cooperative functions involved in the various entities for a fully integrated medical delivery and accounting system. The entities here involved cooperate as a collaborative health care system which offers more efficient delivery of medical care products and services at consequently lower costs, while establishing a vehicle by which all of the participating members in the system can have a voice in fashioning a series of cooperative interrelationships that work to the benefit of each facet of the cooperative.

Detailed Description Text (4):
The system intended for support by the FIG. 1 network is essentially a cooperative of buyers and sellers of products and services used in, or useful to, the health care industry. Such a system might have five or more voting segments with the entities of each segment generally related by similarity of business or professional interest so that no particular vested interest can control the decision making by the cooperative.

Detailed Description Text (8):
Note that the outer loop, including communication links 17, 18, 22, 32, 33 and 37, is intended to indicate that any of the outer terminals on this loop can communicate with one or more terminals likewise on that loop, in addition to communicating with the centralized interface management system 10. Thus, a physician with a primary provider terminal 11 can communicate directly with the terminal 25 of an insurance entity to directly enter a claim upon providing services to an eligible (or at least prospectively eligible) subscriber. In addition, that same physician at a terminal 11 can contact a secondary provider terminal 20, such as for having a prescription filled.

Detailed Description Text (10):
In operation, the cooperative members are provided with an authorizing entry in a

database managed and compiled by the interface system 10 when an appropriate service and fee payment is established by a member user associated with a terminal 30. The individuals are then given an identification code which preferably would take the form of an electronic access card or bank card. This allows access to the substantial technical capacity of member financial and banking services. This feature, including identification, billing and payment mechanisms, represents a potential savings over the administration of contemporary health provision systems.

Detailed Description Text (11):
The overall cooperative is based upon a membership which mutually agrees to the agency cooperative business relationship with potentially democratic management thereof. Thus, a network of interdependent agreements make up the cooperative thereby realizing increased efficiencies and economies of scale while lowering the costs to the members and subscribers. As a result, a managed and collaborative health care marketplace is created that ensures the availability and quality of care in a given locale or region. The cooperative structure can accommodate a single payor, or any third party arrangement, even to the extent of an entire Medicaid or Medicare system as a purchasing member. The arrangement promotes the provision of competitive quality health care services and the collective well being of the cooperative members.

Detailed Description Text (12):
A purchaser database is built and maintained as the responsibility of the agency management 10 and it is administered for the cooperative management system. The agency builds a database of the various members of the cooperative, including listings of providers, facilities, administrators including finance related entities, insurance entities and purchasing members. Whenever a purchasing member has entered the cooperative, the agency management 10 collects enrollment data of the actual health care users from that purchasing member of the cooperative.

Detailed Description Text (13):
The collected data is then transferred to an administrator terminal 35 who creates a database entry. The administrator transfers the enrollment data to a bank such as at another terminal 35, and/or to an insurance terminal 25. The administrator archives the data set as a backup, since the user-accessed database is now available to the bank and/or insurance member.

Detailed Description Text (15):
FIG. 2 presents a general block diagram of the system configuration for a typical data processing network to effectuate the cooperative functions involved in the various entities shown in FIG. 1 for a fully integrated medical delivery and accounting system. The entities here involved cooperate as a collaborative health care system which offers more efficient delivery of medical care products and services at consequently lower costs, while establishing a vehicle by which all of the participating members in the system can have a voice in fashioning a series of cooperative interrelationships that work to the benefit of each facet of the cooperative.

Detailed Description Text (16):
The system intended for support by the FIG. 2 network is essentially a cooperative of buyers and sellers of products and services used in, or useful to, the health care industry. Such a system might have five or more voting segments with the entities of each segment generally related by similarity of business or professional interest so that no particular vested interest can control the decision making by the cooperative.

Detailed Description Text (18):
The financial institution, or bank, is provided with terminals 315. The bank is responsible for providing an electronic card and credit level to each patient for obtaining health care services. The credit level is determined by how much credit the patient could possibly need in a year, i.e. the deductible, coinsurance and copayments up to where the insurance company starts paying 100%. The patient only loses his or her credit by abusing it (not paying bills). Thus, the bank only informs the health care providers whether the patient has credit or not, and the provider does not have to worry about the amount of credit. The bank pays the health care provider immediately after the provider's claim is adjudicated by the insurance company before collecting from the patient. The insurance company and the patient then each pay their share of the claim to the bank.

Detailed Description Text (20):
Once the insurance company adjudicates the claim, the provider is fully reimbursed by the bank for the claim, minus a service charge. The service charge is used to pay for

the bank services, the management service, the data switch and repository 310, and a reserve fund for bad patient debt. Thus, the health care provider does not have to worry about the intricacies of the patient's health care coverage, bad debt, slow payment by the insurance company, or the like. The provider's job consists solely of electronically verifying coverage and credit, providing health care, and submitting a simple electronic claim.

Detailed Description Text (24):
The overall cooperative is based upon a membership which mutually agrees to the agency cooperative business relationship with potentially democratic management thereof. Thus, a network of interdependent agreements make up the cooperative, thereby realizing increased efficiencies and economies of scale while lowering the costs to the members and subscribers. As a result, a managed and collaborative health care marketplace is created that ensures the availability and quality of care in a given locale or region. The cooperative structure can accommodate a single payor, or any third party arrangement, even to the extent of an entire Medicaid or Medicare system as a purchasing member. The arrangement promotes the provision of competitive quality health care services, and the collective well being of the cooperative members.

Detailed Description Text (25):
The FIG. 3 flowchart illustrates the steps followed as a patient uses the services of a health care provider in the cooperative system. Reference to FIG. 2 is helpful in stepping through the flowchart. In step 100, the patient becomes a member of the cooperative. The bank issues the patient an electronic card, and provides a credit level to the patient which would permit the maximum out of pocket expenses which could be accrued by the patient in a year. The bank will verify to providers that the patient has credit, unless the patient does not pay his or her bills, in which case credit is revoked.

Detailed Description Text (26):
In step 102, the patient visits a health care provider, such as a doctor. The doctor verifies in step 104 that the patient has coverage and credit. The doctor may "swipe" the card through a credit card type machine, or may type the patient's identification number into terminal 320. Data switch and repository 310 forwards the eligibility and credit verification request to bank terminal 315. The bank maintains a database of eligibility which is updated by the insurance companies. Data switch and repository 310 records these requests and the responses from the insurance company and bank terminals 325, 315.

Detailed Description Text (32):
FIG. 4 is a diagram showing data switch and repository 310 reports which may be provided to the entities. From the process flow of FIG. 3, it is evident that data switch and repository 310 maintains a database containing every transaction between the entities. Thus, by statistical analysis, it is possible for data switch and repository 310 to generate useful reports based upon these transactions. The reports which data switch and repository 310 generates for each entity depends on what is requested by the entity, and also what the entity is allowed to have in terms of confidentiality.

Detailed Description Text (33):
Block 205 shows the type of reports which might be generated for a health care provider, for example, a doctor. The doctor can access all the details of his or her own patients, including diagnoses, drugs taken, number of visits, and the like. Preferably, the doctor will have to provide both the patients ID number and the doctor's own ID number for access to the information, in order to provide security for the patient's files. The doctor may also access statistical data on all of the patients in the cooperative. Thus, the doctor can find out for all of the patients with a particular condition what drugs were taken, how many doctor visits were necessary for patients taking each drug, etc. It is immediately evident how powerful such statistical reports could be in assessing outcomes and doing cost analysis. Furthermore, the data is automatically collected and maintained, unlike many statistical surveys which rely on doctors exhaustively looking up data, remembering it correctly, and reporting it accurately. Those skilled in the art will appreciate that more complete medical records could also be stored by data switch and repository 310, allowing for more powerful reports.

Detailed Description Text (34):
Block 210 shows the type of reports which might be provided to insurance companies. Again, an insurance company can access detailed data on patients insured with it, and global comparison data among all of the patients in the cooperative. These type of

reports help insurance companies assess risk and determine whether a patient is being appropriately treated.

Detailed Description Text (35):
Block 215 shows the type of reports provided to management services. Management services is responsible for monitoring the transaction which take place in the cooperative and ensuring that the entities meet the requirements set by the cooperative. In addition, management services has the role of looking for more efficient and cost effective ways of doing business. The reports provided by data switch and repository 310 are vital in allowing management services to fulfil these responsibilities. For example, management services monitors the performance of each insurance company by checking how long it takes for each company to adjudicate claims and whether each insurance company is paying meritorious claims as determined by the cooperative. Management services can also monitor the comparative effectiveness of health care providers, both in terms of patient outcomes and cost.

Detailed Description Paragraph Table (1):
ADDENDUM
SYSTEM INTERFACE DEFINITIONS DETAIL INTERFACE DEFINITIONS
STEP 1
PROVIDER CONTRACTS AND PROVIDER DATA BASE JC arranges Provider Organization Service Agreements to be attached to Provider Membership and Agency Contracts. Provider member organization assists in the distribution of JCB Provider Agreements and JustCare Provider Automatic Deposit Authorization forms. When agreements are complete and information available, JC collects and organizes Payor/Payee data for JCB and individual physician data for JCA. MSF #1 Approved Physician/Supplier Information for entry into JCA Data Base JC .fwdarw. JCA JC collects Physician/Supplier information and submits for entry to JCA Data P/E Base, to include: Physician/Supplier I.D. Assigned by JCA - 10 Alpha digits Physician/Supplier Type Code* Physician/Supplier Name Physician/Supplier Title Provider/Payee (Corporate) Name(s) Provider/Payee (Corporate) Tax I.D. Number(s) Physician/Supplier I.D's: Medical License Number DEA Number UPIN or Medicare Number (if required by JustCare) Secondary UPIN Number Individual Tax I.D. Number/Social Security Number JustCare Physician/Provider Organization Specialty 1 Specialty 2 *Note: Provider Type may be a segmented code with three pieces of information, as follows: a) A single alpha code representing the Primary Care Setting (G = Group, I = Individual Practitioner, C = Clinic, H = Hospital, etc) b) A two digit alpha code representing category of primary care (FP = Family Practice) c) A three digit alpha ccde representing subspecialty care (END = Endocrinology) Locations (1 to n) including Provider/Payee location: Street Line 1 Street Line 2 multiples to 6 City (Will publish 3) State Zip Phone MSF #2 JCA Data Base Information to Providers, Insureds, Purchasers, Agents, etc. JCA .rarw..fwdarw. 800 JCA maintains Physician/Supplier Data Base for directory information and T referral calls from other providers, insureds, purchasers, agents, etc. MSF #3a Provider/Payee information to be Provided to JCB by JCA JCA .fwdarw. JCB JCA prepares tape, diskette, or other means (medium to be determined by JCA .fwdarw. JC (PHASE II) receiving organization) to transfer Provider/Payee File (subset of E or P Physician/Supplier file) information to JCB. Information to include: Record Type Numeric (2) JCA ID Alpha (8) Provider/Payee ID Alpha (up to 10) Provider/Payee Name Alpha (36) Primary Mailing Address Line 1 Alpha (30) City State Alpha (22) Zip Numeric (5) Zip Suffix Numeric (4) Phone Number Numeric (10) A/C/I A = ACTIVE Alpha (1) C = CHANGE I = INACTIVE NOTE: JC (or JCA) will deliver Provider/Payee JCB Provider Agreements and Provider/Payee Automatic Deposit Authorization forms to JCB by priority mail. JCB adds the following information to their system from the JCB Provider Agreement and Deposit Authorization Approval Form. Payee Tax ID (EIN) Alpha (9) Bank account number Alpha (17) Transroute Alpha (9) Faxphone Numeric (10) Signer/Contact Alpha (24) MSF #3b Physician/Supplier Information to be Provided to INS/TPA/SF by JCA JCA .fwdarw. INS/TPA/SF if requested by INS/TPA/SF, JCA will supply Total Provider File (i.e. Physician/Supplier JCA .fwdarw. JC (PHASE II) plus Provider/Payee information. E Information to include: Record Type Numeric (2) JCA ID Alpha (8) Provider/Payee or Physician/Supplier Alpha (10) Provider/Payee or Physician/Supplier Alpha (6) Provider/Payee or Physician/Supplier Alpha (36) Address Line 1 Alpha (30) City, State ID Alpha (22) Zip Numeric (5) Zip Suffix Numeric (4) Phone Numeric (10) A/C/I A = ACTIVE Alpha (1) C = CHANGE I = INACTIVE Faxphone Numeric (10) Signer/Contact Alpha (24) Provider/Payee Tax ID (EIN OR S.S. No.) Alpha (9) MSF #4 Access to JCA JustCare Data Base by JC from On-Line Terminal/PC JCA .fwdarw. JC for Inquiry, Verification and Reporting E On-Line Communications are established that enable JC to access information available from JCA Data Base, to include information on Provider/Payees Physicians/Suppliers Utilization Review Claims Purchasers, etc. Reporting mechanisms are initiated and run by JC. Printouts from JCA available upon request. MSF #5 Patient Eligibility and Credit Verification JCB .fwdarw. PRO (PHASE II)

JCB provides equipment and software to Provider/Payee or assists E Provider/Payee with set-up capability (only) for electronic communication w/JCB for online eligibility and credit verification MSF #6 Medical Claims submission PRO .fwdarw. JCA JCA or ECP assists Provider/Payee with set-up capability (only) for E electronic communication for Claim Submission STEP 2 JUSTCARE MEMBERS MARKET JUSTCARE COOPERATIVE TO POTENTIAL PURCHASERS JustCare INS/TPA/SF Members. (Payors) market the JustCare Cooperative through normal channels usually associated with their products. Some INS/TPA/SF members will utilize the services of independent insurance agents. Others may use direct marketing personnel. Third party administrators will inform their employer base directly. Self-funded companies may learn of JustCare through their brokers. Potential purchaser (employer member) will express interest and additional information will be made available through a proposal (insurance quote) received from the direct marketing representative and/or the independent insurance Agent who has an established relationship with a JustCare Insurance Member. TPAs and self-funded employers (or their broker) will work through a JustCare administrative contract to receive pricing information. If the potential PUR accepts the insurance proposal, the membership process begins by completion of Insurance Application materials to include: Insurance or Administration Application JCB Required EFT (Electronic Funds Transfer) Authorization for Premium (if appropriate) Insured Enrollment Information, i.e. Statement of Insurability Enrollment Card Premium Deposit Check (estimated first period premium) Employees complete the following documents for JustCare acceptance: JustCare Individual Consumer Member Application and Agreement Employees receive at this time the JustCare Plan Instruction Packet, which includes a summary of the Articles and Bylaws. The JustCare INS Member Representative (marketing representative or independent agent) delivers all insurance documents to INS. Either Agent or INS delivers to JustCare the JustCare Individual Consumer Member Application and Agreement. INS Member approves or rejects insurance application. Individual Consumer Retains the second copy (pink). JC receives from INS or INS Agent the JustCare Individual Consumer Member Application and Agreement from the Purchasing organization; JC separates the original (white) from the copy (yellow); batches and fogs the originals (white) and retains the copy (yellow) for JustCare's records. * * * * * Since no decision regarding group acceptance is made by TPA/SF organizations, the enrollment process does not have to await

Detailed Description Paragraph Table (2):
acceptance. TPA/SF representative completes with Purchaser the following: Any internal Purchaser acceptance documents JCB required EFT (Electronic Funds Transfer) Authorization for Premium (if appropriate). Premium Deposit Check if appropriate (estimated first period premium) The TPA/SF representative is responsible to see that the Employees complete the following JustCare documents: JustCare Individual Consumer Member Application and Agreement TPA/SF agent delivers to JustCare the JustCare Individual Consumer Member Application and Agreement. The Consumer Member retains the second copy (pink) of this form. JC receives the JustCare Individual Consumer Application and Agreement and separates the original (white) from the copy (yellow). JustCare batches and logs the Individual Consumer Member Application and Agreement, and forwards the original to JCB. The copy (yellow) is retained by JustCare. STEP 2b ENROLLMENT AND BANK CARD PROCESSING DESCRIPTIVE PROCESS FOR PURCHASERS UTILIZING JUSTCARE THROUGH AN INDEMNITY INSURANCE CARRIER: MSF #7 Selected data Regarding Approved Purchaser Group INS .fwdarw. JCA/JC INS .fwdarw. JC (PHASE II-Download) E or P After Purchaser has been approved by INS, INS provides JC/JCA with select data regarding approved Purchaser, to include: *Group Name (Purchaser) *Group Policy Number *Effective Date (Issue Date) *Number of Employees * JCA creates a Master Policyholder File from this information. MSF #8 Group Data: Purchaser Info., Group I.D., Premiums, Enrollment, Account No.s INS .fwdarw. JCB INS .fwdarw. JC (PHASE II/Download) E INS provides Purchaser Information to JCB via electronic transmission. Purchaser information transmitted by INS to JCB: Record Type Numeric (2) JCA ID Alpha (8) INS/TPA/SF Name Alpha (36)* Group Policy Number Alpha (10) Effective Date MMDDYY Numeric (6) Primary Mailing Address Line 1 Alpha (30) Primary Mailing Address Line 2 Alpha (30) City State ID Alpha (22) Zip Numeric (5) Zip Suffix Numeric (4) Phone Number Numeric (10) Fax Phone Number Numeric (10) Payor Cross Reference Alpha (20) * Transfer of INS Name to JC Card limited to 25 characters Enrollment Information transmitted by INS to JCB: Record Type Numeric (2) JCA ID** Alpha (8) INS/TPA/SF ID Alpha (10) Insured's Name (Primary Name) Alpha (25) Primary Birth Date (MMDDYY) Numeric (6) Dependents Numeric (2) * Insured's First Line Address Alpha (30) * insured's Second Line Address Alpha (20) * Insured's City, State ID Alpha (22) * Insured's Zip Numeric (5) * Insured's Zip Suffix Numeric (4) * Insured's Home Phone Number Numeric (10) Insured's Social Security Numeric (9) Insured's Cert/Subscriber No. Alpha (10) Group Policy Number Alpha (10) Additional Reference Alpha (40) (i.e. subsidiary of purchaser, etc.) Cobra Reference (Alpha) (1) Primary Care Provider ID Alpha (10) CoApp (Spouse) Name Alpha (25) CoApp (Spouse) SSN Numeric (9) A/C Alpha (1) A = Add = Issue Card C =

Change = See Step 6 regarding changes which will affect the reissue of a card (same Card Identification Number) Maximum Out of Pocket Numeric (S9,2) * INS to obtain and transfer to JCB. In the event INS is incapable of providing data elements (*'d) to JCB, JCB will obtain and enter data from Cardholder Agreement. ** NOTE: INS/TPA/SF must supply JCA ID. One INS/TPA/SF may utilize more than one JCA. INS/TPA/SF must send separate batches for separate JCA's to JCB. Tier Rating Numeric (1) 1 = Employee Only 2 = Employee & Spouse 3 = Employee & Dependent(s) 4 = Full Family Effective Date of Coverage Numeric Julian Date Credit (Y/N) Alpha (1) Eligible (Y/N) Alpha (1) At this point JCB will have received from JC the JCB Cardholder Application and Agreement. JCB matches with enrollment data downloaded by INS. JCB completes their Insured's Data Base. JCB assigns identifying information to NEWLY INSURED POPULATION Data Base, to include: JCB/insured Account (Card) Number Numeric (16) PHASE I NOTE: JCB will make Insured Data Base available to JC upon request. PHASE II NOTE: When JC has available their own Insured's Data File, it will contain space for a Iisting of dependents and their eligibility as well. This was projected in order to cover the needs of any HMO's or other organization requiring records on insured lives rather than on insured employees. * * * * * * INS will forward to JCB premium payment mechanism for automatic premium withdrawal to be completed by Purchaser. JCB will be responsible for all bank related data in the JCB System. See MSF #8b following: MSF #8b EFT (Electronic Funds Transfer) Form placed on file with JCB INS .fwdarw. JCB (PHASE II) P INS sends to JCB premium payment mechanism (EFT form) for automatic premium withdrawal completd by Purchaser. JCB will be responsible for the entry of all Purchaser bank related data in the JCB System. * * * * * DESCRIPTIVE PROCESS FOR SELF FUNDED PURCHASERS OR PURCHASERS UTILIZING JUSTCARE THROUGH A THIRD PARTY ADMINISTRATOR: MSF #44 Selected Group Data from TPA/SF to JC/JCA TPA/SF .fwdarw. JCA/JC TPA/SF .fwdarw. JC (PHASE II-Download) P TPA/SF Representative provides JC/JCA (with assistance from JC) select data regarding approved TPA "Account" or SF corporation, to include: *Group Name/Purchaser Name *Group Policy Number, if applicable *Effective Date (Issue Date) *Number of Employees * JCA creates a Master Policyholder File from this information. Reference MSF #7 NOTE: TPA/SF Representative delivers to JC the following documents: JustCare Individual Consumer Member Application and Agreement MSF #45 Purchaser/Enrollment Data from TPA/SF to JCB TPA/SF .fwdarw. JCB TPA/SF .fwdarw. JC (PHASE II-Download) E TPA/SF provides Purchaser/Enrollment Information to JCB (with assistance from JC) via electronic transmission. Information to include: Purchaser information transmitted by TPA/SF to JCB: Record Type Numeric (2) JCA ID Alpha (8) TPA/SF Group Name Alpha (36)* Group Policy Number Alpha (10) Effective Date MMDDYY Numeric (6) Primary Mailing Address Line 1 Alpha (30) Primary Mailing Address Line 2 Alpha (30) Purchaser's City State ID Alpha (22) Zip Numeric (5) Zip Suffix Numeric (4)

Detailed Description Paragraph Table (3):
Phone Number Numeric (10) Payor Cross Reference Alpha (20) Enrollment Information transmitted by TPA/SF to JCB: Record Type Numeric (2) JCA ID ** Alpha (8) INS/TPA/SF ID Alpha (10) Insured's Name (Primary Name) Alpha (25) Primary Birth Date (MMDDYY) Numeric (6) Dependents Numeric (2) * Insured's First Line Address Alpha (30) * Insured's Second Line Address Alpha (20) * Insured's City State ID Alpha (22) * Insured's Zip Numeric (5) * Insured's Zip Suffix Numeric (4) * Insured's Home Phone Number Numeric (10) Insured's Social Security Number Numeric (9) Insured's Cert/Subscriber Number Numeric (10) Group Policy Number Alpha (10) * TPA/SF to obtain and transfer to JCB. If TPA/SF is incapable of providing data elements (*'d) to JCB, JCB to obtain from Cardholder Agreement & enter into JCB system. ** NOTE: INS/TPA/SF must supply JCA ID. One INS/TPA/SF may utilize multiple JCA's. INS/TPA/SF must send separate batches for separate JCA's. Additional Reference Alpha (40) (i.e. subsidiary of purchaser, etc.) Cobra Reference (Alpha) (1) Primary Care Provider I.D. (Alpha) (10) CoApp (Spouse) Name Alpha (25) CoApp (Spouse) SSN Numeric (9) A/C Alpha (1) A = Add = Issue Card C = Change = See Step 6 regarding changes which will affect the reissue of a card (same Card Identification Number) Maximum Out of Pocket Numeric (S9,2) Tier Rating Numeric (1) 1 = Employee Only 2 = Employee & Spouse 3 = Employee & Dependent(s) 4 = Full Family Effective Date of Coverage Numeric Jullan Date Credit (Y/N) Alpha (1) Eligible (Y/N) Alpha (1) TPA/SF Representative delivers to JC the following documents: JustCare Individual Consumer Member Application and Agreement JCB assigns identifying JCB codes to NEWLY INSURED POPULATION, to include: JCB/insured Account (Card) No. Numeric (16) PHASE I NOTE: JCB will make TPA Insured Data Base available to JC upon request for labels, statistical analysis, etc. MSF #45b EFT (Electronic Funds Transfer) Form placed on file with JCB TPA .fwdarw. JCB (PHASE II) If appropriate, TPA sends to JCB premium payment mechanism (EFT form) for P automatic premium withdrawal completd by Purchaser. JCB will be responsible for the entry of all Purchaser bank related data in the JCB System. MSF #9 JustCare I.D./Bank Card including data on bank card magnetic stripe JCB .fwdarw. PUR JustCare Card designed by JCB and mailed to Employee Card to contain E/C the following information: Printed Information on front of card: JustCare (name)

Printed Information on back of card: Authorized Signature Line Credit Instructions from JCB JCA Telephone Number for Authorization Requests JCA Name and Address for Claim submission Embossed Information: INS Name or TPA/Employer Name or SF Name JCB/Insured Account (Card) Number JCA Identifier (alpha descriptor)* Insured's Name (Spouse's card carries name of Insured) Insured's Subscriber/Certificate No. (S.S. No.) Tier Rating or Plan Type Group Policy Number Magnetic Stripe Information: JCB/Insured Account (Card) Number ** Indicates those items conveyed by JCB as normally on Magnetic Strip STEP 3 PATIENTS ACCESS JUSTCARE SYSTEM USING JUSTCARE CARD; CAPTURE OF ENCOUNTER DATA BY JCB Patient (Insured or Dependent)/Provider Encounter occurs. Patient presents JC Card to Physician/Supplier for identification and eligibility of insurance. Three methods of receiving verification of eligibility and authentication of credit status are available to Provider/Payee: 1) 800 Number 2) Electronic device (terminal or card swipe machine) 3) Through referral source NOTE: The availability of an authorization number provides assurance and convenience to the Provider/Payee and the patient that an authorization inquiry has been made. The information provided at the time of inquiry is "best information available at the point of inquiry" and does not guarantee future credit availability. METHOD 1: (800 Number) MSF #10 800 Number for Patient Eligibility and Credit Status PRO .fwdarw. JCA Provider/Payee calls JCA on 800 Number and verbally conveys JCB/insured T Account (Card) Number and Provider/Payee Name and/or ID. NOTE: In those situations where a patient may present without the JC Card, Provider/Payee requests from patient the subscriber's name and Social Security Number. This information can be given to JCA in place of the JCB/insured Account (Card) Number. JCA accesses JCB by Insured's Name using the #800 number, and receives Authorization Number if the JCB can match the Insured's Name and Social Security Number. MSF #12 Patient Eligibility & Credit Status to Answer 800 Number Provider Inquiry JCA .rarw..fwdarw. JCB JCA keys JCB/Insured Account (Card) Number and Provider/Payee Number into PC terminal in order to access JCB. MSF .fwdarw. 13b Authorization Number Generated by JCB in Response to Provider 800 Number JCB .fwdarw. JCA Inquiry via JCA E JCB transmits to JCA terminal the following information: JCB/Insured Account No. (Card Number) INS/TPA/SF Name Group Policy Number Insured's I.D. (Social Security/Subscriber/Certificate No.) Insured's Name Authorization Number (if eligibility = Y) (If patient is not eligible for coverage, no Authorization number will be generated, and a message will read "PATIENT NOT ELIGIBLE") Credit Status: (SEPARATE LINE ITEM) Y = Yes Credit Available to read "CREDIT AVAILABLE" N = No Credit Available to read "NO CREDIT AVAILABLE" NOTE: Because JCB will receive inquiries from various JCA's, it is imperative that the Encounter Data be collected by JCA for return of captured data. Also, for reporting purposes the Authorization Number should be used in conjunction with the JCA ID. METHOD 2: (Electronic Device) PHASE II MSF #11 Card Swipe or Keyed Input for Patient Eligibility and Credit Status PRO .rarw..fwdarw. JCB Physician/supplier swipes card or keys input into PC terminal direct to E JCB. JCB accesses JCB Data Base by Card Number. Electronic equipment used identifies Provider/Payee ID. MSF #13a Authorization Number Generated by JCB in Response to Card Swipe NOTE: THIS OPTION NOT YET DEVELOPED BY JCB. JCB .fwdarw. PRO (PHASE II) JCB electronically returns on Printer Box Eligibility, Credit Status & Authorization E Number, as follows: Insured's Name Authorization Number (if Eligibility = Y) (If patient is not eligible for coverage, no authorization number will be generated and message will read: "PATIENT NOT ELIGIBLE") Credit Status (SEPARATE LINE ITEM) Y = Yes = JCB Credit is Available to read "CREDIT AVAILABLE" N = No = JCB Credit is NOT Available to read "NO CREDIT AVAILABLE" Authorization Number Generated by JCB in Response to Keyed Inquiry: NOTE: THIS OPTION UNDER REVIEW BY JCB. JCB .rarw..fwdarw. PRO (PHASE II) T/E JCB electronically returns on Provider/Payee's Terminal information regarding Eligibility, Credit Status, and Authorization as follows: JCB/Insured Account No. (Card Number) INS/TPA/SF Name (whichever is appropriate) Group Policy Number Insured's Subscriber/Certificate Number Insured's Name Authorization Number (if Eligibility = Y (if patient is not eligible for coverage, no Authorization number will be generated, and a message will read "PATIENT NOT ELIGIBLE")

Detailed Description Paragraph Table (4):
Credit Status: (SEPARATE LINE ITEM) Y = Yes Credit Available to read "CREDIT AVAILABLE" N = No Credit Available to read "NO CREDIT AVAILABLE" METHOD 3: (Referral Source) Referring Provider gives Authorization Number to referring Pharmacy, lab, or x- ray provider with referring order or script. MSF #13c Authorization Number Conveyed to Provider/Payee from JCB via JCA JCA .fwdarw. PRO JCA verbally returns to Provider/Payee on 800 Number the Coverage T Status, the Credit Status, and the Authorization Number provided by JCB. * * * * * GENERAL NOTES REGARDING AUTHORIZATION PROCESS: JCB responsible for the creation of an 11-digit authorization numbering system which will ultimately convey four pieces of information. 1) Digit 1: the year of the authorization, by using a single character code (to save space) as follows: A = 1995 B = 1996 etc. to H = 2000 2) Digit 2: A one character code used for indication of an

authorization number that was requested by Provider/Payee). 3) Characters 3-10: A unique sequential number (00,000,001 to 99,999,999), and 4) Character 11: the credit status (Yes or No) A suggested numbering system might be: AJ00000001Y = A = 1995; P = Authorization Number requested by Provider 000000000 1 = Sequential Authorization Number Y = Yes Credit Status; 5) The authorization number will be associated in some reporting instances with the JCA ID (Alpha/Numeric). This will provide several key pieces of data, including the service area for various out of area claims. 2. if an authorization number is not obtained by the Provider, JCA will request an authorization number from JCB when the claim arrives for repricing by JCA, using the following process: a. An attempt is made to find a matching record in the Encounter File, accessing the encounter by Insured's Name or Social Security Number. If the name can be matched to an existing Authorization Number, the number is manually added to the claim. b. If claim cannot be matched to an existing Authorization Number in the Encounter File, JCA will request from JCB an Authorization Number in the usual manner. JCA will replace the default "P", with a "J" in the Authorization Number (second digit) and the number manually entered on the claim. c. Claims which require an Authorization Number to be added by JCA may be set aside for processing and repricing when the Encounter File containing that Authorization Number has been downloaded by JCB to JCA. JCA will convert the "P" code to a "J" code to the Encounter File at the time of processing and repricing (either from the claim or through some other procedural step). 3. Current JCA computer system can accommodate 11 alpha/numeric digits. The above system allows up to 100 million claims per year. 4. Base authorization numbers may be used more than once by different providers when services are connected to the same encounter. MSF #49 Authorization Data Captured for Encounter JCB .fwdarw. JCB JCB captures the data produced during the electronic access for authorization E number through JCB/Insured Account Number. Captured data is stored in an Encounter File for periodic downloading to JCA. (The capture of certain data elements at this point eliminates data entry of those same data elements in the repricing step by JCA). Data elements to be captured include: Record Type Numeric (2) Authorization Number Alpha (11) Authorization Date Numeric (6) Provider/Payee ID Alpha (10) Insured's Name Alpha (25) Insureds Social Security Numeric (9) Insured's Cert/Subscriber Number) Alpha (10) Insureds Street 1 Alpha (30) Insureds Street 2 Alpha (20) City, State ID Alpha (22) Zip Numeric (5) Zip Suffix Numeric (4) Date of Birth Numeric (6) Group Policy Number Alpha (15) Additional Reference Alpha (40) MSF #50 Authorization Data Sent by JCB to JCA JCB .fwdarw. JCA JCA receives Encounter data captured by JCB at time of Authorization through JCB .fwdarw. JC (PHASE II-Download) periodic downloading (MSF #49). These data elements are retrieved by JCA at E time of repricing (by Authorization Number). This step 1) provides accuracy verification of Authorization number, 2) simplifies the process of data entry for JCA and 3) provides JCA with confirmation of Authorization Numbers issued electronically to Provider/Payee (STEP 3, Method 2). NOTE: JCA (or a National JCA) will maintain the active encounter file. Past files will be archived for periodic analysis. JCB can archive their version of the Encounter File (if desired), based on their own requirements. STEP 3b AUTHORIZATION FOR HEALTH SERVICES AND REFERRAL When Physician/Supplier is required to seek U/R approval, the following sequence is followed: MSF #16 Utilization Criteria Review for Health Services and/or Referral PRO .fwdarw. JCA To receive U/R Approval Number Physician/Supplier calls 800 Number at T JCA (or other utilization review organization*) and gives JCA the following information: Physician/Supplier/Identifying Information Insured's Name Patient Name (if dependent of Insured) Group Policy Number Subscriber Number Medical information (Dx, Exam, Proc, etc.) as requested by JCA *Payor Members will have the option of selecting their own utilization review body. MSF #16b U/R Approval or indication of Benefits Status (i.e. not covered, restrictions, etc.) JCA .fwdarw. PRO JCA conveys during telephone interview with Physician/Supplier that T approval for medical procedure or hospital admission is granted or informs Physician/Supplier of any existing restriction. MSF #17 U/R Approval Number for Health Services or Referral JCA .fwdarw. PRO JCA evaluates medical information based on pre-determined criteria. T JCA indicates approval or Benefit Status (i.e. not covered, restrictions, etc.). JCA issues U/R Approval Number to Physician/Supplier by phone and captures in JCA computer system. MSF #17b U/R Approval Number Sent with Claim PRO .fwdarw. JCA Provider/Payee includes U/R Approval Number on Claim when submitted P (mailed) to JCA MSF #18 U/R Approval Number Sent with Claim JCA .fwdarw. INS/TPA JCA sends UIR Approval Number to INS/TPA w/Claim & Repricing Sheet. Note: The U/R Approval number to be designed so that it is distinct from the JustCare Authorization Number, in the following way: P + 000001 (P = Physician = Outpatient) H + 000001 (H = Hospital = Inpatient) STEP 3c PATIENT WITH JUSTCARE CARD ACCESSES NONPARTICIPATING PROVIDER; CLAIMS AND PAYMENTS Since the JustCare Card is available for non-participating physicians and other providers to verify eligibility only, JCA and JCB will need to be able to accommodate these types of calls. To do so, JCB will establish a unique Provider Number only for the purpose of assigning authorization numbers. (Approved by JCB 10/12/94). When JCA receives a call from a

non-participating provider, JCA will enter that unique Provider ID along with the JC Card Number. If the JustCare insured is eligible for coverage, the Authorization number will be supplied to the non- participating provider and the available data captured for the Encounter Data download. MSF #19 800 Number for Coverage Verification. NONPAR PRO .fwdarw. JCA Non-participating Provider calls National JCA 800 Number for information T relative to coverage verification. Non-participating Provider gives to JCA the JCB/Insured Account (Card) Number and Provider Name. MSF #19b JCA contacts JCB via terminal for eligibility of coverage. (same as MSF #12, #13b and 13c) JCB .fwdarw. JCA JCA keys Card Number into PC terminal in order to access JCB. JCB transmits T/E to JCA terminal the following information: JCB/Insured Account No. (Card Number) INS/TPA/SF Name (whichever is appropriate) Group Policy Number Insured's Subscriber/Certificate Number Insured's Name Authorization Number (if Eligibility = Y) (if patient is not eligible for coverage, no Authorization number will be generated and a message will say "PATIENT NOT ELIGIBLE" Credit Status (SEPARATE LINE ITEM)

Detailed Description Paragraph Table (5):
Y = Yes = JCB Credit is Available to read "CREDIT AVAILABLE" N = No = JCB Credit is NOT Available to read "NO CREDIT AVAILABLE" MSF #20 Authorization Number for Coverage Only JCA .fwdarw. NONPAR PRO JCA gives Verification of Eligibility and Authorization Number to Non- T Participating Provider for non-participating claim*. *Credit status not available for non-participating service. MSF #20a Patient Sends Non-Participating Claim to JCA Patient .fwdarw. JCA Having paid (or made arrangements for direct pay) the Non-Participating P Provider, the patient receives a hard copy claim from the Non-Participating Provider. Patient submits claim to JCA with paid receipt (if applicable). * * * OR * * * MSF #20b Non-Participating Provider Receives Assignment and sends Claim with Authorization Number to JCA NONPAR PRO .fwdarw. JCA Non-Participating Provider may request assignment and take P responsibility for Claim Submission to JCA. Non Participating Provider includes Authorization Number on claim, if obtained. MSF #20c JCA Submits Non-Participating Claim to INS/TPA/SF JCA .fwdarw. INS/TPA/SF JCA receives Non-Participating claim from patients and Non-Participating P Providers, captures basic claim data, and forwards without repricing to INS. STEP 3d PATIENT (NEW TO PROVIDER) ACCESSES JUSTCARE PROVIDER WITHOUT JC CARD; CLAIMS AND PAYMENTS Where an unknown Patient fails to present a JustCare Card at the time of treatment, the Provider/Payee may request payment at the time of treatment and/or bill the patient directly. Having paid (or made arrangments for direct pay) the Provider/Payee, the patient receives a hardcopy claim from the Provider/Payee. Patient submits claim to JCA with paid receipt. MSF #23 Claim and Re-Pricing Sheet Prepared by JCA JCA .fwdarw. INS/TPA/SF JCA receives claim from patient, captures all pertinent claim data, and reprices P/E the claim. JCA forwards claim (paper or electronic) and Claim Charge Sheet (Repricing Cover Sheet) to INS/TPA/SF. U/R Approval number (if appropriate) may also be sent to INS, depending upon the U/R procedures in place with INS. NOTE: Refer to Step 4 for a more indepth description of JCA's role to reprice ctaim, collect U/R data and forward claim to INS. "Patient Submitted" Claims are adjudicated by INS; payment determined, and Patient reimbursed by INS/TPA/SF when EOB is sent to Patient. INS/TPA/SF submits EOB as Paid to Provider. Provider reimburses overpayments previously collected from patient (or balance bills patient as appropriate). MSF #21 INS/TPA/SF Sends EOB Summary Data to JC INS/TPA/SF .fwdarw. JC INS/TPA/SF is responsible for sending EOB summary data regarding transaction INS/TPA/SF .fwdarw. JC to JC. EOB data may be sent at time of processing EOB as an additional copy (PHASE II-Download) to JC. Jn PHASE II, information may be sent as a daily download. P EOB information to include: Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) EOB/Claim Number Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered Charges NOTE: Should the Physician/Supplier attempt to determine eligibility of the unknown patient through the JCA and eligibility/credit is determined, the Provider/Payee may proceed with submission of claim as in STEP 4. STEP 4 SUBMISSION AND PRE-PROCESSING OF "YES" COVERAGE/"YES" CREDIT CLAIMS AND "YES" COVERAGE/"NO" CREDIT CLAIMS Having treated a patient (Insured or Dependent), The Provider/Payee submits claim to JCA, regardless of the credit status rating given in the Authorization process. MSF #22 Claim Submission by Provider/Payee with Authorization Number and PRO .fwdarw. JCA Utilization Review Approval P/E Provider sends claim (paper or electronic) to JCA, to include all typical claim information plus: Authorization Number, if obtained, and U/R Approval Number, if appropriate Authorization signature for Insured to assign benefits remains on file with PRO. MSF #23 Preprocessing of Claim and Repricing Sheet JCA .fwdarw. INS/TPA/SF JCA .fwdarw. JC (PHASE I-Hardcopy monthly summary of repriced claim data) JCA .fwdarw. JC (PHASE II-Download) P/E JCA receives claim, captures all pertinent claim data, and reprices claim. JCA forwards Claim (Paper or Electronic) and Claim Charge Sheet (Repricing Cover Sheet) to INS/TPA/SF, to include Authorization Number (regardless of

credit status). U/R Approval Number, if appropriate, may also be forwarded to lNS/TPA/SF depending upon their requirements. STEP 5 PROCESSING AND ELECTRONIC PAYMENT OF "YES CREDIT" CLAIMS MSF #24 and #25 INS Notifies JCB of Insurance Pay Portion and Patient Pay Portion INS/TPA/SF .fwdarw. JCB Having adjudicated the claim INS/TPA/SF transmits to JCB the "Post INS/TPA/SF .fwdarw. JC (PHASE II) Adjudication Claim Payment Data (Charges)" which contain the Insurance Pay E and Patient Pay information as follows: Record Type Numeric (2) INS/TPA/SF ID* Alpha (10) Group Policy Number Alpha (9) EOB/Claim No. Alpha (15) Insured's Social Security No. Alpha (9) Insured's Cert/Subscriber No. Alpha (10) Insured's Name Alpha (25) Patient Pay Amount Numeric (S9,2) Insurance Pay Amount Numeric (S9,2) Patient Name Alpha (25) Patient Social Security Numeric (9) Patient Cert/Subscriber No. Alpha (10) Date of Service Numeric (6) Physician/Supplier Name Alpha (36) Provider/Payee Tax ID (EIN or SS) Alpha (9) * For JC purposes. Number to be assigned by JC to INS/TPA/SF. May consist of JC in-house Member Number. NOTE 1: JCB generates a confirmation fax to INS summarizing the funding request, followed by a mailed confirmation. The detail of these documents is not currently available (12/1/94). NOTE 2: JCB validates the Patient Pay Portion against the Insured's bank credit limit. If the patient pay transaction is within the credit limits allowed by JCB, and if the patient has maintained a "Yes Credit" rating from the point of service, JCB transfers the funds as directed by INS/TPA/SF. If the patient pay portion exceeds the credit limits allowed by JCB or if patient has "lost credit", JCB follows the procedure described in Step 5d. MSF #26 & 27 Patient Pay Amount and Insurance Pay Portion paid through JCB Bank JCB .fwdarw. PRO Account: EFT to Provider/Payee Bank E Having received funding for INS Pay Portion from INS/TPA/SF and having approved "Insured's credit" at the transactional level, JCB transmits to Provider/Payee Bank Account the Insurance Pay Portion AND Patient Pay Portion Dollar Amount (if credit is yes). JCB collects from one day's activity all transactions to be transferred to each Provider/Payee into one sum total. JCB faxes Notice of Transfer to Provider/Payee the day of the funding. Provider/Payee typically would receive funds the next day. Notice of Transfer to include the following items: Provider/Payee Name Total Amount of Transfer Bank Account where funds deposited JCB mails Enhanced Funds Transfer Notification to Provider/Payee for each day's transactions, to include: Header Information: Provider/Payee Name Provider/Payee Address Provider/Payee Tax ID Bank Account Number where funds deposited Line Item information: Date of Transaction Date of Service Patient Name Patient Social Security Number Insureds Name Policyholder Group Number Insureds Certificate/Subscriber Number Payor of Insurance Pay Portion (INS/TPA/SF) EOB Claim Number Physician/Supplier Name Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount

Detailed Description Paragraph Table (6):
Net Payment Amount PHASE II: With electronic capability at the Provider/Payee's location, JCB may convert the Notice by Mail to a electronic download process. The following information is captured by date for download to JC: Date of Transaction Date of Service Provider/Payee JCA ID Insureds JCA ID Policyholder Group Number EOB/Claim Number Insured's Name Insured's Certificate/Subscriber Number Patient Name Patient Social Security (if available) Provider/Payee Name Provider/Payee Tax ID Physician/Supplier Name MSF #54 JC Notifies JCB of Collected Patient Pay Accounts for Transfer to JC .fwdarw. JCB Provider/Payee P/E (PHASE II) Once JC collects (through JC Collection Agency) Patient Payments after assignment by Provider/Payee, JC may notify JCB of amounts held in JC collection account for transfer by JCB to Provider/Payee Account. MSF #55 Patient Pay Amount From JC Collection Account to Provider/Payee by JCB JCB .fwdarw. PRO (PHASE II) JCB electronically transfers amounts paid by Patient from JC collection account E to Provider/Payee Account, faxes/mails confirmation of deposit to Provider/Payee; and collects data for monthly Provider Account Activity Statement (See MSF #26, STEP 5 and 5c). * * * * * * If JC is unable to collect payment from Patient, the uncollected account is returned to Provider as a write-off. NOTE 2: SHOULD A SITUATION OCCUR WHERE THE CREDIT STATUS CHANGES BETWEEN THE POINT OF SERVICE AND THE ACCOUNTING TRANSACTION MADE BY JCB, JCB WILL PROCESS TRANSACTION WITH CREDIT INFORMATION AVAILABLE AT TIME OF TRANSACTION TRANSFER. a) IF CREDIT CHANGES FROM "YES" TO "NO", PROVIDER/PAYEE WILL HAVE TO BALANCE BILL THE INSURED FOR ANY AMOUNT REMAINING DUE. b) IF CREDIT CHANGES FROM "NO" TO "YES", BANK WILL TRANSFER THE PATIENT PAY PORTION FROM JCB'S FUNDS TO THE PROVIDER. SHOULD THIS RESULT IN AN OVERPAYMENT TO PROVIDER (BECAUSE THE PROVIDER/PAYEE APPROPRIATELY COLLECTED FUNDS FROM A "NO CREDIT" PATIENT), THE PROVIDER/PAYEE WILL REFUND OVERPAYMENT TO INSURED. The method of notification of "No Credit" Transactions to JC by JCB will change as the volume of "no credit" transaction increases, as follows: PHASE I: Faxed information plus notation on JCB Claims Summary Account Statement (MSF #30) PHASE II: Download information plus plus notation on JCB Claims Summary Account Statement (MSF #30) STEP 5e ACCESS TO JUSTCARE

RESERVE ACCOUNT BY JCB AND BAD DEBT COLLECTION A. After monthly billing to Insured by JCB (see MSF #48 - STEPS 5 and 5c), the following billing sequence is established by JCB: 1) Initial billing provides 30 days for receipt of payment without interest or finance charges. 2) If Full or Required Payment* is not received by Due Date, JCB sends second billing at 30 days, with interest and/or finance charges added, giving a Final Due Date (an additional 30 days past the second billing). * If Required Payment is less than $25, $25 is the Required Payment B. If full or partial payment is not received by Final Due Date, JCB transfers responsibility for Debt Collection to JC at 90 days. This will be done by batch processing to coincide with Final Due Date Notices. The Insured's hard copy file will be turned over to JC to include: 1) Name and demographic data of Insured 2) Insured Statement Activity (historical) giving the detail of all patient encounters not paid 3) Total Balance Due plus Interest and Finance Charges 4) Collection process incurred by JCB (a) Datè Notices given (b) Content of Notices given (i.e Standard Letter #2, etc.) (c) Collection history (i.e. phone conversations, etc) (d) Whether or not there is an alleged dispute 5) A hard copy Credit Bureau Report Note: JC will determine whether or not the Account should be turned to Collection or should be charged against the JC Reserve as a "can't pay" Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount Net Payment Amount [TO BE DETERMINED] Amount Denied Credit - Referred back to Provider for Collection MSF #48 JCB Bills Patient for Patient Pay Portion JCB .fwdarw. Insured JCB sends a monthly statement to Insured, showing claim activity P Information to include: JCB/Insured Account (Card) Number Insured's (CardHolder) Name Insured's (CardHolder) Address, Zip Date of Transaction Date of Service Line Item Description, to include EOB/Claim Number Patient First Name Physician/Supplier Name Patient Pay Dollar Amount Payment since Last Statement Minimum Payment Terms of Payment Balance Due Payment Due Date Concurrently: MSF #21 INS/TPA/SF Produces EOB and Distributes to Provider & Patient INS/TPA/SF .fwdarw. PRO/PATIENT INS/TPA/SF prepares EOB (Explanation of Benefits) and sends copies to PRO P and Patient. MSF #31 INS/TPA/SF Forwards EOB Data to JC INS/TPA/SF .fwdarw. JC/JCA INS/TPA/SF .fwdarw. JC (PHASE II-Download) P INS/TPA/SF is responsible for sending EOB summary data regarding transaction to JC. EOB data may be sent at time of processing EOB as an additional copy to JC. In PHASE II, information may be sent as a daily download. EOB Information to Include: Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) EOB/Claim Number Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered Charges STEP 5b PROCESSlNG AND ELECTRONIC PAYMENT OF "NO" CREDIT CLAIMS AND PAYMENTS MSF #24 & 25 INS Notifies JCB of Insurance Pay Portion and Patient Pay Portion INS/TPA/SF .fwdarw. JCB Having adjudicated the claim, INS/TPA/SF transmits to JCB the "Post INS/TPA/SF .fwdarw. JC (PHASE II) Adjudication Claim Payment Data (Charges)," which contain the Insurance Pay E Portion and Patient Pay Portion information as follows: Record Type Numeric (2) INS/TPA/SF ID* Alpha (10) Group Policy Number Alpha (10) EOB/Claim Number Afpha (15) Insured's Social Security Numeric (9) Insured's Cert/Subscriber Number Numeric (10) Insured's Name Alpha (25) Patient's Name Alpha (10) Patient Social Security Alpha (10) Patient Cert/Subscriber Number Numeric (9) Date of Service Numeric (6) Physician/Supplier Name Alpha (36) Provider/Payee I.D. (EIN or S.S.) Alpha (10) Patient Pay Amount Numeric (S9,2) Insurance Pay Amount Numeric (S9,2) * For JC purposes. Number to be assigned by JC to INS/TPA/SF. May consist of JC in-house Member Number. NOTE 1: JCB generates a confirmation fax to INS summarizing the funding request, followed by a mailed confirmation. If the transfer is not possible, JCB conveys to INS/TPA/SF the following information: Name of INS/TPA/SF

Detailed Description Paragraph Table (7):
Group Policy Number Insured's Name Insured's Social Security Number Insured's Cert/Subscriber Number Patient Pay Amount Insurance Pay Amount Provider/Payee Tax ID Reason for inability to transfer funds NOTE 2: JCB validates the Patient Pay Portion against the Insured's bank credit limit. Since there was no credit available at time of Authorization, the assumption is that no credit will be available at time of transaction. JCB follows the procedure described in STEP 5d, MSF #53. MSF #27 Insurance Pay Amount from INS/TPA/SF ACH Account: EFT to Provider/Payee JCB .fwdarw. PRO Bank E Having received funding for INS Pay Portion from INS/TPA/SF, JCB transmits to Provider/Payee Bank Account the Insurance Pay Portion. JCB adds to Provider's daily activity record all transactions to be transferred to that Provider/Payee that represent INS/TPA/SF payments only. JCB faxes Notice of Transfer to Provider/Payee the day of the funding. Provider/Payee receives funds the following day (normally). Notice of transfer to include: Provider/Payee Name Total Amount of Transfer Bank Account Number where funds deposited JCB mails Enhanced Funds Transfer Notification to Provider/Payee for each day's transactions, to include Header Information:

Provider/Payee Name Provider/Payee Address Provider/Payee Tax ID Bank Account Number where funds deposited Line Item Information: Date of Transaction Date of Service Patient Name Patient Social Security Number Insureds Name Policyholder Group Number Insureds Certificate/Subscriber Number Payor of Insurance Pay Portion (INS/TPA/SF) EOB Claim Number Physician/Supplier Name Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount Net Payment Amount PHASE II: With electronic capability at the Provider/Payee's location, JCB may convert the Notice by Mail to a electronic download process. The following information is captured by date for download to JC: Date of Transaction Date of Service Provider/Payee JCA ID Insureds JCA ID Policyholder Group Number EOB/Claim Number Insured's Name Insured's Certificate/Subscriber Number Patient Name Patient Social Security (if available) Provider/Payee Name Provider/Payee Tax ID Physician/Supplier Name Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount Net Payment Amount [TO BE DETERMINED] Amount Denied Credit - Referred back to Provider for Collection Concurrently: MSF #21 INS/TPA/SF Produces EOB and Distributes to Provider & Patient Line Item Information: INS/TPA/SF .fwdarw. PRO/PATIENT INS/TPA/SF prepares EOB (Explanation of Benefits) and sends copies to PRO P and Patient. MSF #31 INS Forwards EOB Data to JC INS/TPA/SF .fwdarw. JC/JCA INS/TPA/SF is responsible for sending EOB data regarding transaction to JC. INS/TPA/SF .fwdarw. JC (PHASE II-Download) EOB data may be sent at time of processing EOB as an additional copy to JC. P In PHASE II, information may be sent as a daily download. EOB Information to Include: Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID EOB (Claim) Number Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered Charges STEP 5c INSURANCE PAYMENT ALTERNATIVE: DIRECT PAYMENT TO PROVIDER BY INS/TPA/SF PROCESSING OF PATIENT PAY BY JUSTCARE BANK JustCare will provide an option whereby an INS/TPA/SF may request to use the JustCare Card for the patient pay portions, but elects to send INS/TPA/SF portion directly to the Provider. If this were to occur, the standard JustCare procedures would be utilized, except that the INS/TPA/SF would forward only patient pay portion notification to JCB. NOTE: Patient Pay Portions are subject to the same Administrative Fee charges identified in the Appendix. Insurance Pay Portions would be subject to an access fee calculated and paid by INS/TPA/SF directly to JC. [TO BE DETERMINED] * * * * * * After receipt of and adjudication of claims, INS/TPA/SF processes the Insurance Pay Portion manually through their own internal accounting and check writing processes. The Patient Pay Portion Only is forwarded to JCB for processing as follows: MSF #25 INS/TPA/SF Notifies JCB of Patient Pay Portion INS/TPA/SF .fwdarw. JCB INS/TPA/SF transmits to JCB the "Post Adjudication Claim Payment Data INS/TPA/SF .fwdarw. JC (PHASE II-Download) (Charges)", which includes Patient Pay Information as following: E Record Type Numeric (2) INS/TPA/SF ID* Alpha (10) Group Policy Number Alpha (10) EOB/Claim Number Alpha (15) Insured's Social Security Numeric (9) Insured's Cert/Subscriber No. Alpha (10) Insured's Name Alpha (25) Insurance Pay Amount Numeric (S9,2) (Insur Pay Amount will always be $0.00 when INS/TPA/SF processes Insurance Payments manually) Patient Pay Amount Numeric (S9,2) Patient Name Alpha (25) Patient Social Security Numeric (9) Patient Cert/Subscriber No. Alpha (10) Date of Service Numeric (6) Physician (Supplier Name Alpha (36) Provider/Payee I.D. (EIN or S.S.) Alpha (9) * For JC purposes. Number to be assigned by JC to INS/TPA/SF. May consist of JC in-house Member Number. NOTE: JCB validates the Patient Pay Portion against the Insured's bank credit limit. If the patient pay transaction is within the credit limits allowed by JCB, and if the patient has maintained a "Yes Credit" rating from the point of service, JCB proceeds with the transaction. If the patient pay portion exceeds the credit limits allowed by JCB or if patient has "lost credit", then JCB follows the procedure described in STEP 5d. MSF #26 Patient Pay Amount Advanced from JCB Bank Account: EFT to Provider/Payee Bank JCB .fwdarw. PRO Having received the funding for the INS Pay Portion from INS/TPA/SF and E having approved the "Insured's credit" at the transactional level, JCB transmits to Provider/Payee Bank Account the Patient Pay Portion Dollar Amount. JCB collects from one day's activity all transactions to be transferred to each Provider/Payee into one sum total. JCB faxes Notice of Transfer to Provider/Payee the day of the funding. Provider/Payee typically would receive funds the next day. Notice of Transfer to include the following items: Provider/Payee Name Total Amount of Transfer Bank Account where funds deposited JCB mails Enhanced Funds Transfer Notification to Provider/Payee for each day's transactions, to include: Header Information: Provider/Payee Name Provider/Payee Address Provider/Payee Tax ID Bank Account Number where funds deposited Line Item Information: Date of Transaction Date of Service Patient Name Patient Social Security Number Insureds Name Policyholder Group Number Insureds Certificate/Subscriber Number Payor of Insurance Pay Portion (INS/TPA/SF) EOB Claim Number Physician/Supplier

Name

Detailed Description Paragraph Table (8):
Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount Net Payment Amount PHASE II: With electronic capability at the Provider (Payee's location, JCB may convert the Notice by Mail to a electronic download process. The following information is captured by date for download to JC: Date of Transaction Date of Service Provider/Payee JCA ID Insureds JCA ID Policyholder Group Number EOB/Claim Number Insured's Name Insured's Certificate/Subscriber Number Patient Name Patient Social Security (if available) Provider/Payee Name Provider/Payee Tax ID Physician/Supplier Name Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount Net Payment Amount [TO BE DETERMINED] Amount Denied Credit Referred back to Provider for Collection MSF #48 JCB Bills Patient for Patient Pay Portion JCB .fwdarw. Insured JCB sends a monthly statement to Insured, showing claim activity. P Information to include: JCB/Insured Account (Card) Number Insured's (CardHolder) Name Insured's (CardHolder) Address, Zip Date of Transaction Date of Service Line Item Description, to include: EOB/Claim Number Patient First Name Physician/Supplier Name (as much as will fit) Patient Pay Dollar Amount Payment since Last Statement Minimum Payment Terms of Payment Balance Due Payment Due Date Concurrently: MSF #21 Insurance Company Produces EOB and Distributes to Provider & Patient INS/TPA/SF .fwdarw. PRO/PATIENT INS/TPA/SF prepares EOB (Explanation of Benefits) and sends copies to P Provider/Payee and Patient. MSF #31 INS Forwards EOB Data to JC INS/TPA/SF .fwdarw. JC/JCA INS/TPA/SF is responsible for sending EOB data regarding transaction to JC. INS/TPA/SF .fwdarw. JC (PHASE II-Download) EOB data may be sent at time of processing EOB as an additional copy to JC. P In PHASE II, information may be sent as a daily download. EOB Information to Include: Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) EOB/Claim Number Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered Charges

STEP 5d
VALIDATION OF PATIENT CREDIT LIMIT AND CREDIT RATING BY JCB; SUBSEQUENT PAYMENT PROCESSING Upon receipt of claim adjudication and reimbursement detail from INS/TPA/SF (MSF #25 for both Yes Credit and No Credit), JCB conducts an internal review and validation of Patient Pay Portion prior to the advancement of funds to Provider/Payee. JCB's review process validates Patient's Account based on two criteria: 1) Has the Patient exceeded the Credit Limit imposed by JCB; and 2) Has the Patient lapsed into a "No Credit" rating. If both tests are negative, JCB proceeds with the next step described in MSF #26, STEPS 5, 5b and 5c. If either of these tests are affirmative, JCB will post the Patient Pay portion onto a JCB Credit Exception List. JCB has the option to evaluate any Patient appearing on the Credit Exception List and to extend credit to them in the normal fashion. (See Continuation after MSF #26, STEPS 5, 5b and 5c). JCB may also elect to report "no credit" and "credit exceptions" to JustCare, rather than to extend credit to a patient where their credit limits have been exceeded or where the patient has become delinquent since the original authorization was given. MSF #53 JCB Forwards "No Credit" Patient Data to JC JCB .fwdarw. JC JCB verifies credit status on all Insureds prior to making daily funds transfer P/E (MSF #26). JC is notified of any patient pay transaction that cannot be transferred because of "no credit" on the day following identification. JCB faxes to JC information from the Post Adjudication Claim Record, to include: JCA ID Insured's Name Insured's Cert/Subscriber Number Patient's Name Patient Social Security Date of Service Physician/Supplier Name Provider/Payee Name, Provider/Payee I.D. EOB/Claim Number Patient Pay Amount PHASE II NOTE: When JCB is capable of downloading "No Credit" Patient informtion, it is recommended that JCB download the entire "Post Adjudication Claim" Record. In Phase I JustCare will receive faxed information and notifies Provider/Payee for Balance Billing to Insured. After a single billing, the Provider/Payee has option to assign collection duties to JC. If authorization to collect patient pay amounts has been given to JC by Provider and, if circumstances warrant, JC combines the above listed information with the Insured's Data File and submits to the JC Collection Agency for collection proceedings. JC Collection Agency proceeds with precollect and collection efforts. If and when collected, JC Collection Agency notifies JC and deposits funds into JC Account. During Phase I period, JC will transfer monies collected by JC Collection Agency to Provider/Payee by Check. * * * * * * NOTE: JCB TO DETERMINE THE FEASIBILITY OF THE FOLLOWING TWO MSF INTERACES, #54 AND 55, AT A LATER TIME: 6) Date and Amount of Debit to JC Reserve Account with detail to include Insured's Name and Provider/Payee Name and Amount. C. JC receives JCB data regarding Bad Debt accounts and enters into JC Reserve Accounting

System. 1) JC prepares and forwards Notice to Provider/Payees with Demand Statement for bad debts incurred by Insureds reported by JCB and judged by JC as "having the ability to pay" and those categorized as "disputed claims." Notice includes offer to Provider/Payee to assign Bad Debt back to JC for legal collection. 2) JC creates a follow-up method for return of funds and Assignment Statement from Provider/Payee. (a) JC Posts funds received from Provider/Payee to JC Reserve (b) JC forwards Bad Debt Assignments to JC Collection Agency (1) Funds collected by JC Collection Agency are reported to JC and deposited with JC. (2) JustCare sends check for funds collected to JCB to replenish JC Reserve. 3) JC identifies "can't pay" Bad Debt Accounts and analyzes for proper action, to include: (a) Write off by JC Board of Directors (b) Collection efforts by JC Collection Agency (i) Amounts collected by JC Collection Aency are reported to and Deposited with JC (ii) Deposited amounts transferred by JC to JC Reserve (iii) Payment arrangements or judgement activity (liens, garnishments, etc) arranged by JC Collection Agency are maintained by JC Collection Agency and payments forwarded to JC as they become available. MONTHLY (OR AS DETERMINED) REPORTING ACTIVITY BY JCB FOR STEPS 5, 5b AND 5c: JCB is responsible to provide summary information on all insurance funding requests and the detail of all provider fund transfers to JC on a periodic basis. These steps are in a state of revision and only outline information is available. MSF #28 I. Provider/Payee Account Activity Statement JCB .fwdarw. PRO (PHASE I-Hardcopy) JCB .fwdarw. PRO (PHASE II-May be downloaded to some Providers) P Account Activity Statement has been replaced by the Enhanced Funds Transfer Notification (See MSF #26 and 27) to the Provider. MSF #29 II. Insurance Company Account Activity Statement JCB .fwdarw. INS/TPA/SF (PHASE I-Hard Copy)

Detailed Description Paragraph Table (9):
JCB .fwdarw. INS/TPA/SF (PHASE II-Download) P MSF #29 is in the process of being eliminated and replaced by a Confirmation for INS funding request by facsimile (fax) followed by a mailed notification of the same or enhanced information. Details are not presently available. (12/1/94) MSF #30 III. JCB Claims Summary Account Statement with JC Reserve Breakout JCB .fwdarw. JC (PHASE I) JCB .fwdarw. JC (PHASE II-Download) PART A JCB is responsible to provide periodic downloads to JustCare of all information captured at the time of provider funds transfer. See MSF #26 and 27. Data elements to be included are: Date of Transaction Date of Service Provider/Payee JCA ID Insureds JCA ID Policyholder Group Number EOB/Claim Number Insured's Name Insured's Certificate/Subscriber Number Patient Name Patient Social Security (if available) Provider/Payee Name Provider/Payee Tax ID Physician/Supplier Name Gross Amount of Each Transaction Amount of JustCare Discount Amount of Insurance Pay Portion Amount of Patient Pay Portion Disbursed to Provider through JC Cardholder Account Amount of Provider Discount Net Payment Amount [TO BE DETERMINED] Amount Denied Credit - Referred back to Provider for Collection JC is responsible for internal analysis reporting and disbursement of any INS/TPA/SF specific or global reporting to INS/TPA/SF. PART B JCB is Responsible to provide to JC a Statement of JC Reserve General Ledger Account activity. The form of this report has not been fully determined. NOTE: NOT INCLUDED IN THE PROVIDER ACTIVITY REPORTS IS THE INCLUSION OF THE PROVIDER DISCOUNT SUBTRACTED FROM THE PATIENT PAY PORTION. INCLUSION OF THE PROVIDER DISCOUNTS IN MONTHLY REPORTING WILL BE DETERMINED AT A LATER TIME. MONTHLY (OR BY ARRANGEMENT) REPORTING ACTIVITY BY INS/TPA/SF (for STEPS 5, 5b and 5c): INS/TPA/SF is responsible to provide reports of claim activity to JC, including Summary EOB Data and adjudication of Dollar Amounts. Reports are identified I.-III. below. (MSF #31, 32 and 33) MSF #31 I. Combined EOB and Electronic Paid Claims Report INS/TPA/SF .fwdarw. JCA/JC INS/TPA/SF sends combined EOB and/or Paid Claims Report to JC/JCA. INS/TPA/SF .fwdarw. JC (PHASE II) Report to contain: P/E* Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) EOB/Claim Number Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered Charges MSF #32 II. Non-Participating Claims Data and Combined EOB Report INS .fwdarw. JC/JCA INS sends Combined EOB and/or Paid Claims Report for Non-Participating INS/TPA/SF .fwdarw. JC (PHASE II) Services to JC/JCA. Report to Contain: P/E* Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) EOB/Claim Number Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered Charges MSF #33 II. EOB Report of Patient Direct Paid Claims INS/TPA/SF .fwdarw. JCA INS/TPA/SF sends Combined EOB and/or Paid Claims Report for Patient INS/TPA/SF .fwdarw. JC (PHASE II) Direct Paid Claims. Report to include: P/E* Date of Transaction (ACH Date) Date of Service Group Policy Number Provider/Payee Name Provider/Payee Tax ID Insured Name Insured's Certificate Number Patient Name Patient Social Security (if available) EOB/Claim Number Billed Charges Amount Appropriate Discounts Exclusions: COB, etc. Insurance Pay Portion Patient Pay Portion Non Covered

Charges PERIODIC REPORTING ACTIVITY BY JCA: (PHASE I) JCA is responsible to provide a utilization reporting process to JC and to PRO organizations (IPAs, PHOs, Hospitals, etc.) These reports will detail all claim activity and will include: Provider Organization Designation Provider/Payee Name/ID Code Physician/Supplier Name Provider Type Code JustCare Authorization Number Insured's Name Insured's Certificate/Subscriber Number Patient Name Patient Social Security Number (if Available) INS/TPA/SF Name Group Policy Number Date of Birth Sex of Employee Date of Service Location (Hospital, office, ER, ambulatory surgical center, etc.) Procedure Codes, Drug Codes, etc. with Description Diagnosis Code (to include a maximum of 3 ICD-9-CM codes if available from claim submission) and Description Billed Charges Repriced Charges STEP 6 ON-GOING MAINTENANCE: ENROLLMENT ADDITIONS, CHANGES AND DELETIONS MSF #34 Additions, Changes, and Deletions for Purchasers, Insureds and Dependents Purchaser .fwdarw. INS/TPA/SF Purchaser may incur corporate changes that need to be forwarded to P INS/TPA/SF. Purchaser would report: Group Name (need in all circumstances for identification) Group Number (need in all circumstances for identification) and provide the following types of changes: Purchaser Address changes Purchaser Phone Number changes Change of Bank information As enrollment additions, changes and deletions occur, PUR forwards* to INS/TPA/SF appropriate change information to reflect: Enrollment Data and Effective Dates of New Employees Name and Effective Date of Terminated Employees Name Changes Address Changes Dependent Additions or Deletions Tier Rating Changes Employment Status Changes - rehire, reinstate, on leave, etc. COBRA Changes * PUR may report changes to INS/TPA/SF by letter, through forms designed and made available by INS/TPA/SF, or uses an electronic download method. MSF #35 Additions, Changes, and Deletions for Purchasers, Insureds and Dependents INS/TPA/SF .fwdarw. JCB E or P PURCHASER CHANGES: Purchaser Changes that affect the JCB Purchaser Record are reported to INS/TPA/SF will be downloaded to JCB by INS/TPA/SF, to include: Purchaser Address Purchaser Phone Number Purchaser Changes that affect a Change of Bank Account Authorization information will require hard copy documentation and data entry by JCB. As enrollment additions, changes and terminations are received by INS/TPA/SF, INS/TPA/SF processes enrollment changes and downloads to JCB a new insured's Record for each affected employee reflecting the addition, change or deletion. NEW EMPLOYEES AND LATE ENROLLEES, TO INCLUDE: Record Type Numeric (2) JCA ID Alpha (8) INS/TPA/SF ID Alpha (10) Insured's Name (Primary Name) Alpha (25) Primary BirthDate (MMDDYY) Numeric (6) Dependents Numeric (2) * Insured's First Line Address Alpha (30) * Insured's Second Line Address Alpha (20) * Insured's City, State ID Alpha (22) * Insured's Zip Numeric (5) * Insured's Zip Suffix Numeric (4) * Insured's Home Phone Number Numeric (10) * INS/TPA/SF to obtain and transfer to JCB. In the event INS/TPA/SF is incapable of providing data elements (*'d) to JCB, JCB

Detailed Description Paragraph Table (10):
will obtain from Cardholder Agreement and enter into their system. Insured's Social Security Number Numeric (9) Insured's Cert/Subscriber Number Alpha (10) Group Policy Number Alpha (10) Additional Reference Alpha (40) (i.e. subsidiary of purchaser, etc.) Cobra Reference (Alpha) (1) Primary Care Provider ID (Alpha) (10) CoApp (Spouse) Name Alpha (25) CoApp (Spouse) SSN Numeric (9) A/C A = Add = Issue Card Alpha (1) Maximum Out of Pocket Numeric (S9,2) Tier Rating Numeric (1) 1 = Employee Only 2 = Employee & Spouse 3 = Employee & Dependent(s) 4 = Full Family Effective Date of Coverage Numeric Julian Date Credit (Y/N) Alpha (1) Eligible (Y/N) Alpha (1) INS/TPA/SF responsible for the completion and delivery of the following form to JC: JustCare Individual Consumer Member Application and Agreement INS/TPA/SF delivers to JustCare the JustCare Individual Consumer Member Application and Agreement. If necessary, INS Member approves or rejects insurance application. Individual Consumer Retains the second copy (pink). JC receives from INS/TPA/SF the JustCare Individual Consumer Member Application and Agreement; JC separates the original (white) from the copy (yellow); batches and logs the originals (white) and retains the copy (yellow) for JustCare's records. JCB receives original JustCare Individual Consumer Member Application and Agreement from JC and receives download of insured's data from INS/TPA/SF. JCB enters Insured/Individual Consumer Member into into JCB data base and assigns: JCB/Insured Account (Card) Number. * * * * * * FOR TERMINATED EMPLOYEES: INS/TPA/SF transmits Insured's Record noting an Eligible = N on a Change Record. JCB receives above information into data base and overlays Insured's Record with the change. Change Indicated is Eligible = N. The transfer by INS/TPA/SF will be made on the effective date of termination. Once the overlay has been made, the insured is no longer eligible for coverage. Note: COBRA RECIPIENTS WILL BE TREATED AS NEW EMPLOYEE AND WILL RECEIVE NEW JCB/INSURED ACCOUNT CARD AND NUMBER. PURCHASER WILL REPORT EMPLOYEE'S DATE OF TERMINATION AND WILL REPORT SEPARATELY THE COBRA applicant submit the following form: JustCare Individual Consumer Member Application and Agreement * * * * * FOR CHANGES INCURRED BY INSURED converting A/C Record Code Value to "C" = Change. Record remains active with data changes replacing previous data. NOTE: If JCB receives an Insured's Record where the A/C flag =

C, changes to the following data elements would prompt JCB to reissue a JC Card (same account, same account number): Insured's Name Group Policy Number Certificate Number Tier Rating JCA Identifier In addition to the above, the following events initiated by INS/TPA/SF would trigger the establishment of a new account, also requiring the issuance of new cards: Election of COBRA by terminated Employees or Dependents of Employee (the Insured) Employment changes by Employee from one JC Payor Member to another JC Payor Member Lost Cards reported to JCB would initiate a manual process by JCB to replace the card and may require that a new account be established. STEP 6b ON GOING MAINTENANCE: PREMIUM UPDATES - PHASE II Prior to funds transfer, INS/TPA sends monthly premium information to PUR, relating current enrollment and premium information. PUR responds to INS/TPA with any changes to enrollment. MSF #36 Premium Updates for Billing Purchaser INS/TPA .fwdarw. JCB INS/TPA receives enrollment updates from PUR and determines increases, E decreases, etc. to overall premium structure. INS/TPA notifies JCB by download process. Information to include: Purchaser (Group) Number Purchaser (Group) Name Updated Monthly Premium for Group STEP 7 AUTOMATED PREMIUM COLLECTION BY JCB NOTE: STEP 7 AND 7b ARE PHASE II OPERATIONS TO BE APPROVED PRIOR TO IMPLEMENTATION A. Monthly Premium Collection Having received the adjusted premium amount (or using the prior month's premium amount if no updates have occurred), INS mails to Purchaser notification of monthly premium. JCB then debits the Purchaser' JCB Account for the designated monthly premium amount. MSF #37 JCB EFT's premium from Purchaser's Bank Account, or Purchaser sends check PUR Bank .fwdarw. JCB to INS for premium. or PUR .fwdarw. JNS E/P Premium billing or Notice of Intent to Transfer Premium Dollar amount sent to Purchaser by INS. On predetermined date JCB EFT's premium amount from Purchaser's bank account to JCB. Sequence of notification and collection activity to be predetermined by INS/TPA/SF and JC B. Collection of Past Due Premiums and Cancellation of Purchaser for Non-Payment of Premium MSF #38 If Insufficient Funds for Electronic Transfer, JCB Notifies INS JCB .fwdarw. INS Failure to transfer funds from PUR's bank account results in notice of E/P insufficient funds. JCB notifies INS through JCB's most efficient means (i.e. paper, electronic, etc.) (Note: See MSF #47 for more detail on account "Hold" status.) MSF #39 If Insufficient Funds, INS notifies Purchaser that 31 day grace period has INS .fwdarw. PUR commenced. (Grace Period starts from premium due date.) P After receiving notice from JCB that PUR's account produced insufficient funds, INS sends paper document notice to PUR by overnight mail giving notice of insufficient funds and alerting PUR that 31 day grace period has begun. MSF #40 JCB EFT's Premium from JCB Insurance Company Account to INS bank account JCB .fwdarw. INS JCB EFT's premium collected since last transfer (daily) to INS Co. Bank E Account, itemized by Group Number and accompanied by an information transmittal document. MSF #47 INS Notifies JCB to Cancel All JC Cards for Canceled Group INS .fwdarw. JCB If no payment is forthcoming after 31 day Grace Period, INS notifies JCB E to cancel all JustCare Cards for Canceled Group. C. Treatment of Claims during Premium Past Due Collection Period MSF #41 Upon Expiration of 31 Day Grace Period, INS returns Claims Held to PRO INS .fwdarw. PRO Any PRO claims received during the 31 day grace period are held by INS P until determination of premium payment. If no payment received, any claims held will be returned to PRO, marked "No Coverage, No Credit." MSF #41b Upon Expiration of 31 Day Grace Period, INS Forwards Unpaid EOB to Insured INS .fwdarw. JC Any PRO claims received during the 31 day grace period are held by INS P until determination of premium payment. If no payment received, INS forwards copy of Unpaid EOB to Insured. MSF #41c Upon Expiration of 31 Day Grace Period, INS Notifies JC of Claims Returned INS .fwdarw. JC Any PRO claims received during the 31 day grace period are held by INS P until determination of premium payment. If no payment received, INS forwards copy of Unpaid EOB to JC. D. Monthly Premium Reporting Activity by JCB MSF #42 Premium Account Activity Statement to INS JCB .fwdarw. INS JCB provides monthly statement showing account activity of all premium P notices from INS and all Premium transfers made. Statement to include: Statement Date By group, the following premium information: Beginning Balance (Premium Paid since last Statement) Total Premium Notices received from INS during month Total Premium Transfers made from PUR to JCB Total Premium Transfers made from JCB to INS Ending Balance (Showing Premium Paid to Date at End of Month MSF #43 Premium Account Activity Statement to JC

Detailed Description Paragraph Table (11):
JCB .fwdarw. JC JCB provides monthly statement showing account activity of all premium P notices collected from all INS and all Premium transfers made. Statement to include: Statement Date INS Name Group Name Group Policy Number Beginning Balance by Group Name and Number (Premium Paid since last Statement) Total Premium Notices received from INS during month Total Premium Transfers made from PUR to JCB Total Premium Transfers made from JCB to INS Ending Balance for each Group (Premium Paid to Date at End of Month) Total Premiums Collected at End of Month for each INS STEP 7b PREMIUM COLLECTION FOR DIRECT PAYMENT TO INS A. Monthly Premium Collection by INS Where INS chooses or is incapable of receiving automatic premium collection or where PUR elects not to

authorize automatic premium payments, the notification of monthly premium will be considered an invoice, payable in 30 days, and PUR will pay invoice manually by check or money order. B. Collection of Past Due Premiums to INS and Cancellation of Purchaser for Nonpayment of Premium If PUR fails to make payment of monthly premium to INS on a timely basis, INS will notify Purchaser that a 31-day grace period has commenced. Patient then has an additional 31 days to make payment of premium. If payment is not received during the 31-day grace period, INS notifies JCB that all JC cards are canceled for the group. MSF #47 INS Notifies JCB to Cancel All JC Cards for Canceled Group INS .fwdarw. JCB If no payment is forthcoming after 31 day Grace Perfod, INS notifies JCB E to cancel all JustCare Cards for Canceled Group. Note: If JCB agrees, JCB can put entire account on hold status for 30 days for possible reinstatement. JC/Insured Account Cards would also be placed on a "Hold" status. Use of the card would then generate a "no coverage, no credit" response when used by a Provider to verify eligibility. When the JustCare Cards are canceled, INS must notify the Purchaser that all coverage has been canceled. Purchaser must then notify Insured that coverage has ceased and that JustCare cards are no longer activated. INS must also notify JC of Notice of Cancellation. If Purchaser remits monthly premium past the 31-day grace period, the Group Policy may be reinstated by INS, in which case this information also would be provided to JC. C. Treatment of Claims during Premium Past Due Collection Period MSF #41 Upon Expiration of 31 Day Grace Period, INS returns Claims Held to PRO INS .fwdarw. PRO Any PRO claims received during the 31 day grace period are held by INS P until determination of premium payment. If no payment received, any claims held will be returned to PRO, marked "No Coverage, No Credit." MSF #41b Upon Expiration of 31 Day Grace Period, INS Forwards Unpaid EOB to Insured INS .fwdarw. JC Any PRO claims received during the 31 day grace period are held by INS P until determination of premium payment. If no payment received, INS forwards copy of Unpaid EOB to insured. MSF #41c Upon Expiration of 31 Day Grace Period, INS Notifies JC of Claims Returned INS .fwdarw. JC Any PRO claims received during the 31 day grace period are held by INS P until determination of premium payment. If no payment received, INS forwards copy of Unpaid EOB to JC. D. Monthly Premium Reporting Activity by INS MSF #46 Premium Collected Report INS .fwdarw. JC INS provides to JC a monthly report of Total Premiums Collected directly P from Purchaser (checks or money orders). Report to include: Statement Date Date of Receipt of Payments Amount Received by Group Number Number of Employees APPENDIX SEQUENCE OF ACTIVITY REGARDING JUSTCARE TRANSACTIONAL FEES The sequence of activity regarding the JustCare transactional Administrative Fee and the Provider Discount is as follows: MSF #23 JCA adds transactional administrative fee to priced claim. Transactional Administrative Fee is added to and becomes a part of the priced claim by JCA. INS/TPA/SF receives and adjudicates claim, inclusive of any transactional administrative fee. MSF #24 & 25 INS/TPA/SF transmits Post Adjudication claim data, broken out into INS/TPA/SF Pay Portion and Patient Pay Portion, to the JCB. MSF #26 (Patient Pay Portion) JCB debits the credit card account JCB credits Internal JCB/Credit Card Account JCB debits the Internal JCB/Credit Card Account JCB credits the JC Account the transactional administrative fee JCB credits balance to the Provider Account, less Provider Discount (Merchant Fee) JCB transfers balance by electronic deposit to Provider Bank Account MSF #27 (Insurance Pay Portion) JCB debits the Payor Account *INS/TPA/SF by ACH transfer JCB credits an Internal JCB/Payor Account JCB debits the Internal JCB/Payor Account JCB credits the JC Account the transactional administrative fee JCB credits balance to the Provider Account JCB transfers balance by electronic deposit to Provider Bank Account JCB debits the Internal JCB/Payor and Credit Card Account JCB credits 1) the JC Account (administrative Transactional Fee) 2) the JCB Provider Account JCB faxes/mails daily confirmation notice of transactional administrative fee detail with monthly summary reporting.

KEY: JC: JustCare PRO: Provider/Payee E: Electronic P: Paper JCA: JustCare Administrator JCB: JustCare Bank PUR: Purchaser C: Card TPA/SF: Third Party Administrator/Self Funded ECP: Electronic Claims Processor INS: Insurance Co. 800: 800 Phone No. T: Telephone

CLAIMS:

1. A method for effectuating a cooperative health care provision and management agency system through a data switch and repository device, said method comprising the steps of:

configuring said agency system to serve only a plurality of entities who have mutually agreed to participate in said agency system by way of a plurality of interdependent agency agreements executed by said plurality of entities;

said plurality of entities including health care providers, at least one financial institution, at least one insurance organization, a management service having said data

switch and repository device, purchasing members who have one or more health care users as members, and health care users who qualify as an insurance organization via self insurance;

said mutual agreement to participate in said agency system by way of said plurality of interdependent agency agreements including authority mutually granted by said plurality of entities to said at least one insurance organization to adjudicate claims that are transmitted by said health care providers to said at least one insurance organization;

providing for said data switch and repository device to communicate data transmission among said plurality of entities and to record transactions between said plurality of entities;

compiling an entity list at said data switch and repository device, said entity list listing said plurality of entities;

updating said entity list as changes in a status of any of said plurality of entities occur;

electronically transmitting an inquiry from a given health care provider to said data switch and repository device relative to a given user;

electronically responding to said inquiry by transmitting a verification from said data switch and repository device to said given health care provider that said given user is eligible to receive care as an entity of said agency system;

electronically transmitting a claim from said given health care provider to said at least one insurance organization, said claim including codes indicating a diagnosis and treatment provided to said given user;

adjudicating at said at least one insurance organization said transmitted claim, and electronically notifying said given health care provider of the results of said adjudication;

responding to a favorable result of said adjudicating step by electronically transmitting a direction from said at least one insurance organization to a financial institution, said transmission authorizing said financial institution to pay said claim to the extent that said at least one insurance organization has adjudicated that said claim is payable; and

electronically transmitting from said at least one insurance organization to said given health care provider an explanation of benefits as determined from said adjudication.